Filing at a Glance

Company:	Loyal American Life Insurance Company
Product Name:	Loyal FDC/FDH
State:	Arkansas
TOI:	H07I Individual Health - Specified Disease - Limited Benefit
Sub-TOI:	H07I.001 Critical Illness
Filing Type:	Form/Rate
Date Submitted:	07/08/2012
SERFF Tr Num:	UTAC-127366519
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	LOYAL FDC/FDH
Implementation Date Requested:	On Approval
Author(s):	Alycia Sumbera, Joyce Kostakis, Melissa Garza, Melissa MacLaurin, Julie Cook
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/07/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

General Information

Project Name: Loyal FDC/FDH
Project Number: Loyal FDC/FDH
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Julie Cook

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/07/2012
State Status Changed: 09/07/2012
Created By: Alycia Sumbera
Corresponding Filing Tracking Number:

Filing Description:

Re: Loyal American Life Insurance Company
NAIC # 65722 FEIN # 63-0343428

NEW POLICY FORMS DESCRIPTION
LY-FDC-BA-AR First Diagnosis Cancer Insurance Policy
LY-FDC-BA.SCH.PG-AR Schdule Page for First Diagnosis Cancer Insurance Policy
LY-FDH-BA-AR First Diagnosis Heart and Stroke Insurance Policy
LY-FDH-BA.SCH.PG-AR Schdule Page for First Diagnosis Heart and Stroke Insurance Policy
LY-FDC-RD First Diagnosis Cancer Rider
LY-FDH-RD First Diagnosis Heart and Stroke Rider
LY-SD-RD Specified Disease Rider
LY-ADD-RD3 Accidental Death and Dismemberment Rider
LY-ROP-D Return of Premium Rider
LY-ROP-D85 Return of Premium (85) Rider
LY-ROP-T15 Return of Premium Upon Termination (15 Years) Rider
LY-ROP-T20 Return of Premium Upon Termination (20 Years) Rider
LY-FDC-OC-GN First Diagnosis Cancer Outline of Coverage
L-FDH-OC-GN First Diagnosis Heart and Stroke Outline of Coverage
LY-FDCH-APP-GN FDC and FDH Application
LY-FDC-APP.V2-GN FDC Application
LY-FDH-APP.V2-GN FDH Application
Actuarial Memorandum Rates

Dear Sir or Madam:

These forms are new and do not replace any forms previously approved by your department. The riders will be used with the First Diagnosis Cancer policy and the First Diagnosis Heart & Stroke policy described above as well as any future approved supplemental health products. The policy form and riders described above will be sold through licensed agents.

If there are any questions or comments, please call me at (800) 633-6752 extension 4874, fax me at (512) 451-0357 or email me at jcook4@gafri.com.
Sincerely,
Julie Cook, MCM

State: *Arkansas* ***Filing Company:*** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Compliance Filing Specialist

Company and Contact

Filing Contact Information

Julie Cook, Compliance Specialist
11200 Lakeline Blvd.
Suite 100
Austin, TX 78717

JCook4@gafri.com
512-807-4874 [Phone]
512-451-0357 [FAX]

Filing Company Information

Loyal American Life Insurance Company
11200 Lakeline Blvd., Suite 100
P.O. Box 559004
Austin, TX 78755-9004
(800) 633-6752 ext. [Phone]

CoCode: 65722
Group Code: 84
Group Name:
FEIN Number: 63-0343428

State of Domicile: Ohio
Company Type: Insurance Company
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$600.00
Retaliatory?	Yes
Fee Explanation:	12 FORMS X $50 - $600.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Loyal American Life Insurance Company	$600.00	07/08/2012	60719109

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2012	09/07/2012
Approved-Closed	Rosalind Minor	08/17/2012	08/17/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	07/16/2012	07/16/2012

Response Letters

Responded By	Created On	Date Submitted
Alycia Sumbera	08/17/2012	08/17/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Application	Alycia Sumbera	09/07/2012	09/07/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Re-0pen filing	Note To Filer	Rosalind Minor	09/07/2012	09/07/2012
Reopen filing	Note To Reviewer	Alycia Sumbera	08/29/2012	08/29/2012

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Disposition

Disposition Date: 09/07/2012
Implementation Date:
Status: Approved-Closed
Comment:

The filing was reopened at your request in order to replace the V2 applications. The new V2 applications are being approved effective on this date and the old applications are being withdrawn.

The remainder of the filing will maintain the original approval date of 8/17/12.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Loyal American Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #: UTAC-127366519 **State Tracking #:** **Company Tracking #:** LOYAL FDC/FDH

State: Arkansas **Filing Company:** Loyal American Life Insurance Company
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Loyal FDC/FDH
Project Name/Number: Loyal FDC/FDH/Loyal FDC/FDH

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document (revised)	Application	Approved-Closed	Yes
Supporting Document	Application	Withdrawn	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	First Diagnosis Cancer Insurance Policy	Approved-Closed	Yes
Form	First Diagnosis Cancer Insurance Policy	Replaced	Yes
Form (revised)	First Diagnosis Heart and Stroke Insurance Policy	Approved-Closed	Yes
Form	First Diagnosis Heart and Stroke Insurance Policy	Replaced	Yes
Form	First Diagnosis Cancer Rider	Approved-Closed	Yes
Form	First Diagnosis Heart Rider	Approved-Closed	Yes
Form	Specified Disease Rider	Approved-Closed	Yes
Form	Return of Premium Rider	Approved-Closed	Yes
Form	Return of Premium (85) Rider	Approved-Closed	Yes
Form	Return of Premium Upon Termination (20 Year) Rider	Approved-Closed	Yes
Form	Return of Premium Upon Termination (15 Year) Rider	Approved-Closed	Yes
Form	First Diagnosis Cancer Schedule Page	Approved-Closed	Yes
Form	First Diagnosis Heart and Stroke Schedule Page	Approved-Closed	Yes
Form	Accidental Death and Dismemberment Rider	Approved-Closed	Yes
Rate	FDC Policy Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDH Policy Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDC Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDH Rider Actuarial Memoradum/Rates/Exhibits	Approved-Closed	No

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Rate	SD Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (85) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (20 Years) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (15 Years) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	AD&D Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Disposition

Disposition Date: 08/17/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Loyal American Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #: UTAC-127366519 **State Tracking #:** **Company Tracking #:** LOYAL FDC/FDH

State: Arkansas **Filing Company:** Loyal American Life Insurance Company
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Loyal FDC/FDH
Project Name/Number: Loyal FDC/FDH/Loyal FDC/FDH

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document (revised)	Application	Approved-Closed	Yes
Supporting Document	Application	Withdrawn	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	First Diagnosis Cancer Insurance Policy	Approved-Closed	Yes
Form	First Diagnosis Cancer Insurance Policy	Replaced	Yes
Form (revised)	First Diagnosis Heart and Stroke Insurance Policy	Approved-Closed	Yes
Form	First Diagnosis Heart and Stroke Insurance Policy	Replaced	Yes
Form	First Diagnosis Cancer Rider	Approved-Closed	Yes
Form	First Diagnosis Heart Rider	Approved-Closed	Yes
Form	Specified Disease Rider	Approved-Closed	Yes
Form	Return of Premium Rider	Approved-Closed	Yes
Form	Return of Premium (85) Rider	Approved-Closed	Yes
Form	Return of Premium Upon Termination (20 Year) Rider	Approved-Closed	Yes
Form	Return of Premium Upon Termination (15 Year) Rider	Approved-Closed	Yes
Form	First Diagnosis Cancer Schedule Page	Approved-Closed	Yes
Form	First Diagnosis Heart and Stroke Schedule Page	Approved-Closed	Yes
Form	Accidental Death and Dismemberment Rider	Approved-Closed	Yes
Rate	FDC Policy Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDH Policy Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDC Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	FDH Rider Actuarial Memoradum/Rates/Exhibits	Approved-Closed	No

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Rate	SD Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (85) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (20 Years) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	ROP (15 Years) Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No
Rate	AD&D Rider Actuarial Memorandum/Rates/Exhibits	Approved-Closed	No

State: Arkansas **Filing Company:** Loyal American Life Insurance Company
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Loyal FDC/FDH
Project Name/Number: Loyal FDC/FDH/Loyal FDC/FDH

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/16/2012
Submitted Date	07/16/2012
Respond By Date	08/16/2012

Dear Julie Cook,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Under Part 2, Eligibility and effective date of coverage, coverage for all minors for whom the insured has filed a petition to adopt must be for 60-days as outlined under ACA 23-79-137.

Objection 2

Comments:

With respect to your Exclusion #1, Rule and Regulation 18, 1 A(3) states that specified disease policies shall provide benef\its to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

Objection 3

Comments:

Under Part 6, Termination of Coveage Provision, and with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/17/2012
Submitted Date	08/17/2012

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

Part 2 Eligibility and Effective date of coverage has been revised to comply with ACA 23-79-137.

Related Objection 1

Comments:

Under Part 2, Eligibility and effective date of coverage, coverage for all minors for whom the insured has filed a petition to adopt must be for 60-days as outlined under ACA 23-79-137.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: UTAC-127366519 **State Tracking #:** **Company Tracking #:** LOYAL FDC/FDH

State: Arkansas **Filing Company:** Loyal American Life Insurance Company
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Loyal FDC/FDH
Project Name/Number: Loyal FDC/FDH/Loyal FDC/FDH

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	LY-FDC-BA-AR	POL	First Diagnosis Cancer Insurance Policy	Initial	40.000	LY-FDC-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
Previous Version							
1	*LY-FDC-BA-AR*	*POL*	*First Diagnosis Cancer Insurance Policy*	*Initial*	*40.000*	*LY-FDC-BA-AR AS FILED.pdf*	*Date Submitted: 08/17/2012 By: Alycia Sumbera*
2	LY-FDH-BA-AR	POL	First Diagnosis Heart and Stroke Insurance Policy	Initial	40.000	LY-FDH-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
Previous Version							

SERFF Tracking #: *UTAC-127366519* **State Tracking #:** **Company Tracking #:** *LOYAL FDC/FDH*

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	LY-FDC-BA-AR	POL	First Diagnosis Cancer Insurance Policy	Initial	40.000	LY-FDC-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
2	*LY-FDH-BA-AR*	*POL*	*First Diagnosis Heart and Stroke Insurance Policy*	*Initial*	*40.000*	*LY-FDH-BA-AR AS FILED.pdf*	*Date Submitted: 08/17/2012 By: Alycia Sumbera*

No Rate/Rule Schedule items changed.

Response 2

Comments:

The FDC and FDH policies/riders and SD rider provide a lump sum benefit upon diagnosis of one of the covered specified disease which can be used to pay for the treatment of any other conditions or diseases directly caused or aggravated by the specified disease or treatment of the specified disease. This policy does not provide expense reimbursement benefits. Once the Maximum Benefit Amounts have been paid, the policy terminates. No changes were made.

Related Objection 2

Comments:

With respect to your Exclusion #1, Rule and Regulation 18, 1 A(3) states that specified disease policies shall provide benefi\its to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

SERFF Tracking #:	UTAC-127366519	**State Tracking #:**		**Company Tracking #:**	LOYAL FDC/FDH

State:	Arkansas	**Filing Company:**	Loyal American Life Insurance Company
TOI/Sub-TOI:	H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness		
Product Name:	Loyal FDC/FDH		
Project Name/Number:	Loyal FDC/FDH/Loyal FDC/FDH		

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

The child termination provision has been revised to comply with ACA 23-85-131(b).

Related Objection 3

Comments:

Under Part 6, Termination of Coveage Provision, and with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: UTAC-127366519 **State Tracking #:** **Company Tracking #:** LOYAL FDC/FDH

State: Arkansas **Filing Company:** Loyal American Life Insurance Company
TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness
Product Name: Loyal FDC/FDH
Project Name/Number: Loyal FDC/FDH/Loyal FDC/FDH

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	LY-FDC-BA-AR	POL	First Diagnosis Cancer Insurance Policy	Initial	40.000	LY-FDC-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
Previous Version							
1	*LY-FDC-BA-AR*	*POL*	*First Diagnosis Cancer Insurance Policy*	*Initial*	*40.000*	*LY-FDC-BA-AR AS FILED.pdf*	*Date Submitted: 08/17/2012 By: Alycia Sumbera*
2	LY-FDH-BA-AR	POL	First Diagnosis Heart and Stroke Insurance Policy	Initial	40.000	LY-FDH-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
Previous Version							

SERFF Tracking #: *UTAC-127366519* **State Tracking #:** **Company Tracking #:** *LOYAL FDC/FDH*

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	LY-FDC-BA-AR	POL	First Diagnosis Cancer Insurance Policy	Initial	40.000	LY-FDC-BA-AR_8.17.12.pdf	Date Submitted: 08/17/2012 By: Alycia Sumbera
2	*LY-FDH-BA-AR*	*POL*	*First Diagnosis Heart and Stroke Insurance Policy*	*Initial*	*40.000*	*LY-FDH-BA-AR AS FILED.pdf*	*Date Submitted: 08/17/2012 By: Alycia Sumbera*

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Alycia Sumbera

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Amendment Letter

Submitted Date: 09/07/2012

Comments:

Thank you for reopening this filing. The new FDC and FDH applications have been uploaded to the supporting documents tab.

Thank you
Alycia

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment:

LY-FDCH-APP-GN_10.18.11.pdf
LOYAL-FDC-S.App.pdf
LY-FDC-APP-GN_10.18.11.pdf
LY-FDH-APP-GN_10.18.11.pdf

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Note To Filer

Created By:

Rosalind Minor on 09/07/2012 09:22 AM

Last Edited By:

Rosalind Minor

Submitted On:

09/07/2012 09:22 AM

Subject:

Re-0pen filing

Comments:

The file has been re-opened as requested.

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Note To Reviewer

Created By:

Alycia Sumbera on 08/29/2012 02:48 PM

Last Edited By:

Alycia Sumbera

Submitted On:

08/29/2012 02:48 PM

Subject:

Reopen filing

Comments:

Dear Ms. Minor,

In preparation for the release of this product to the market we discovered problems with the filng of the V2 application. The V2 application was created to change the formatting, the content is the same. We would like to withdraw the V2 applications and file the original application that was approved in a majority of the states.

It would be greatly appreciated if you could reopen this filing to upload the corrected form.

Your time and consideration is greatly appreciated.

Sincerely
Alycia Sumbera

SERFF Tracking #: *UTAC-127366519* **State Tracking #:** **Company Tracking #:** *LOYAL FDC/FDH*

State: *Arkansas* **Filing Company:** *Loyal American Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Loyal FDC/FDH*
Project Name/Number: *Loyal FDC/FDH/Loyal FDC/FDH*

Form Schedule

Lead Form Number: LY-FDC-BA

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/17/2012	LY-FDC-BA-AR	POL	First Diagnosis Cancer Insurance Policy	Initial:	40.000	LY-FDC-BA-AR_8.17.12.pdf
2	Approved-Closed 08/17/2012	LY-FDH-BA-AR	POL	First Diagnosis Heart and Stroke Insurance Policy	Initial:	40.000	LY-FDH-BA-AR_8.17.12.pdf
3	Approved-Closed 08/17/2012	LY-FDC-RD	POLA	First Diagnosis Cancer Rider	Initial:	40.000	LY-FDC-RD.pdf
4	Approved-Closed 08/17/2012	LY-FDH-RD	POLA	First Diagnosis Heart Rider	Initial:	40.000	LY-FDH-RD.pdf
5	Approved-Closed 08/17/2012	LY-SD-RD	POLA	Specified Disease Rider	Initial:	40.000	LY-SD-RD.pdf
6	Approved-Closed 08/17/2012	LY-ROP-D	POLA	Return of Premium Rider	Initial:	40.000	LY-ROP-D.pdf
7	Approved-Closed 08/17/2012	LY-ROP-D85	POLA	Return of Premium (85) Rider	Initial:	40.000	LY-ROP-D85.pdf
8	Approved-Closed 08/17/2012	LY-ROP-T20	POLA	Return of Premium Upon Termination (20 Year) Rider	Initial:	40.000	LY-ROP-T20.pdf
9	Approved-Closed 08/17/2012	LY-ROP-T15	POLA	Return of Premium Upon Termination (15 Year) Rider	Initial:	40.000	LY-ROP-T15.pdf
10	Approved-Closed 08/17/2012	LY-FDC-BA.SCH.PG-AR	SCH	First Diagnosis Cancer Schedule Page	Initial:	0.000	LY-FDC-BA.SCH.PG-AR AS FILED.pdf
11	Approved-Closed 08/17/2012	LY-FDH-BA.SCH.PG-AR	SCH	First Diagnosis Heart and Stroke Schedule Page	Initial:	0.000	LY-FDH-BA.SCH.PG-AR AS FILED.pdf

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Lead Form Number: LY-FDC-BA

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
12	Approved-Closed 08/17/2012	LY-ADD-RD3	POLA	Accidental Death and Dismemberment Rider	Initial:	40.000	LY-ADD-RD3.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Loyal American
Life Insurance Company®

[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS CANCER INSURANCE POLICY

Here is Your new First Diagnosis Cancer Insurance Policy. The language used is easy to understand. Loyal American Life Insurance Company® will be referred to in this policy as "We", "Our", and "Us". "You" or "Your" means the Named Insured.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

RIGHT TO ADJUST FUTURE PREMIUMS. After this policy has been in force for twelve (12) months, We may change the premium rates only if We change them for all policies like Yours in Your state on a premium class basis. A premium class basis is determined by such factors as benefits, age, gender, geographic location, tobacco use and the year the policy is issued. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. If We change the premium rates for all policies of this form issued by Us and in force in Your state, We will inform You in writing at least thirty (30) days before the change occurs at the address shown in Our records.

PRE-EXISTING CONDITION(S). The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s).

IMPORTANT NOTICE! PLEASE READ. Please read the copy of the application attached to this policy. The best time to clear up any questions is now, before a claim arises. Omissions or misstatements in the application could cause an otherwise valid claim to be denied or coverage to be rescinded. Carefully check the application and write to Loyal American Life Insurance Company at [P.O. Box 559004, Austin, Texas 78755-9004] within ten (10) days if any information shown on it is not correct and complete or if any medical history has been left out. The application is a part of this policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

YOU HAVE THE RIGHT TO EXAMINE THIS POLICY FOR THIRTY (30) DAYS. Please read Your policy carefully. If You are not satisfied with Your policy for any reason, You may return the policy to Us. It must be returned within thirty (30) days from receipt of this policy. If returned, the policy will be void from its beginning as though the policy was never issued. Any premium paid on this policy will be refunded.

NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY. THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
REDUCED BENEFITS WILL BE PROVIDED DURING THE FIRST THIRTY (30) DAYS IMMEDIATELY FOLLOWING THE EFFECTIVE DATE OF THIS POLICY FOR ANY CLAIMS RESULTING FROM CANCER OR CARCINOMA IN SITU.

Brenda Hardison

Secretary

President

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PART 1: DEFINITIONS

When We use the following words, this is what We mean:

ADVICE OR TREATMENT means care or services provided by a Physician or other member of the medical profession, acting within the scope of their license, including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition, "Advice or Treatment" does not include Maintenance Drug Therapy or routine follow-up visits to verify if Cancer or Carcinoma in Situ has returned.

BENEFICIARY means the person(s) You named in the application, or by later designation, to receive any death benefit or accrued benefits unpaid at Your death.

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

CANCER means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Blood cancers such as Leukemia, Myelodysplastic Syndrome (MDS) and lymphoma are included. Cancer must be Diagnosed pursuant to a Pathological or Clinical Diagnosis.

While not an exhaustive list, the following premalignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this policy:
(1) pre-malignant lesions (such as intraepithelial neoplasia);
(2) benign tumors or polyps;
(3) early prostate cancer Diagnosed as T1N0M0 or equivalent staging;
(4) Carcinoma in Situ; or
(5) any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

CARCINOMA IN SITU means a Diagnosis of Cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ must be Diagnosed pursuant to a Pathological or Clinical Diagnosis. Carcinoma in Situ includes, but is not limited to:
(1) early prostate cancer Diagnosed as T1N0M0 or equivalent staging; and
(2) melanoma not invading the dermis.

Carcinoma in Situ does not include:
(1) other skin malignancies;
(2) pre-malignant lesions (such as intraepithelial neoplasia); or
(3) benign tumors or polyps.

CHILD(REN) means Your natural child, stepchild, legally adopted child, a child placed with You for adoption, a foster child, or court appointed guardianship/order/administrative order for a child including grandchild, who is:
(1) insurable and named on the application;
(2) unmarried;
(3) chiefly dependent on You or Your Spouse for support; and
(4) has not attained the limiting age of nineteen (19) or twenty-six (26) if enrolled as a full-time student in an accredited school or college.

Child(ren) also includes dependent child(ren), regardless of age, who:
(1) are mentally or physically handicapped;
(2) became or become handicapped prior to the limiting Age; and
(3) cannot support themselves because of their handicap.

CLINICAL DIAGNOSIS means the Diagnosis of Cancer or Carcinoma in Situ based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer or Carcinoma in Situ only if the following conditions are met:

(1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
(2) there is medical evidence to support the Diagnosis; and
(3) a Physician is treating the Insured Person for Cancer and/or Carcinoma in Situ.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this policy, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records. This includes recurrence of a previously Diagnosed Cancer provided the Insured Person has not received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

DEPENDENTS means Your Spouse and Child(ren) as defined under this section.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of Cancer or Carcinoma in Situ through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this policy.

FIRST EVER DIAGNOSIS means the Diagnosis is the first time ever in the Insured Person's lifetime they have been Diagnosed with Cancer or Carcinoma in Situ.

IMMEDIATE FAMILY means anyone related to an Insured Person in the following manner: the Spouse, father (including stepfather), mother (including stepmother), sons (including stepsons), daughters (including stepdaughter), brothers or sisters (including stepbrothers or stepsisters), grandchildren, or father-in-law or mother-in-law of any Insured Person.

INSURED PERSON means the person(s) named in the policy application or subsequently added and who were approved for coverage by Us until death, lapse of coverage due to non-payment of premiums, cancellation of policy upon the Named Insured's request, or under the Termination of Coverage and Conversion Privileges Provisions.

MAINTENANCE DRUG THERAPY means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of Cancer due to primary treatment. It is meant to decrease the risk of Cancer recurrence rather than the palliative or suppression of Cancer that is still present.

NAMED INSURED means the primary person accepted for coverage by Us, who is described in the application and has completed and signed the application.

PATHOLOGICAL DIAGNOSIS means a Diagnosis of Cancer or Carcinoma in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical Advice or Treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the policy.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this policy is in force.

SKIN CANCER means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, mycosis fungoides or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.

SPOUSE means the person who is lawfully married and named on the application as the Spouse to be insured at the time You first applied for this coverage, or who was added at a later date. There may never be more than one (1) Spouse insured at any given time.

PART 2: ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

AT THE TIME THE POLICY IS ISSUED: Before coverage becomes effective for each Insured Person:
(1) You must apply;
(2) We must approve Your application; and
(3) You must pay the required premium.

Applicants must be acceptable to Us based on Our underwriting rules in effect at the time of application to become an Insured Person. The effective date of insurance for each such person will be the Effective Date shown on the Policy Schedule Page.

PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE: Eligible Dependents not covered under the policy when the policy is issued may be added later. To do so, We must receive:
(1) a new application for each Dependent;
(2) evidence satisfactory to Us that such Dependent is eligible and insurable according to Our underwriting guidelines; and
(3) payment of the additional required premium.

The Effective Date of coverage for the added Insured Person will be the later of the date on which We approve the application or the date upon which We receive any additional required premium.

COVERAGE OF NEWBORN OR ADOPTED CHILD(REN): Any Child born to You while this policy is in force is automatically covered from the moment of birth for ninety (90) days or until the next premium due date, whichever is later. For coverage to continue We must receive notice (which must include the Child's name, gender and date of birth) within ninety (90) days of such Child's birth or before the next premium due date, whichever is later, and You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notice.

Any Child who is under Your charge, care, and control and whom You have filed a petition to adopt is automatically covered for sixty (60) days from the date of the filing of a petition for adoption. In the case of a newborn, the coverage shall be from the moment of birth if the petition is filed within sixty (60) days after the birth of such Child. For coverage to continue We must receive notice (which must include the Child's name, gender, date of birth and date of the filing of a petition for adoption) within sixty (60) days from the date of the filing of a petition for adoption and You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notice.

PART 3: BENEFITS PROVIDED BY THIS POLICY

FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician, We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

(1) 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
(2) the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

(1) Diagnosis must be made within the United States; and
(2) the Date of Diagnosis shall occur while the Insured Person is covered by this policy; and

(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the policy. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this policy's Effective Date, coverage for the Insured Person under the this policy will end.

PART 4: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy:

(1) for any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
(2) loss that begins prior to the Effective Date of coverage;
(3) Diagnosis and treatment received outside the United States or its territories; or
(4) any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 5: PREMIUM PAYMENTS AND REINSTATEMENT

INITIAL: This policy is issued based on the application, Our underwriting requirements and payment of the initial premium. The policy begins on the Effective Date shown on the Policy Schedule Page. All periods of insurance will begin and end at 12:01 a.m., at the place where You live.

RENEWAL: All renewal premiums must be paid in consecutive terms. They shall be paid by modes currently offered by Us. Renewal premiums are payable to Us. Premiums must be paid on or before the date due or before the end of the grace period. If this policy should lapse, the payment of a premium will reinstate this policy only as provided in the reinstatement provision in this section.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium, falling due after the first premium. This policy will continue in force during the grace period. If the premium due is not paid during the grace period, the policy will terminate coverage at the end of the period for which premiums were paid.

LAPSE AND REINSTATEMENT: If the renewal premium is not paid within the grace period, this policy will terminate on the first premium due date for which premium was not paid. If the policy terminates, Our acceptance of a premium payment without requiring an application for reinstatement will reinstate this policy. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

If We require an application for reinstatement and issue a conditional receipt, this policy will be reinstated upon Our approval of the reinstatement application. If We do not notify You in writing of Our prior approval or disapproval, this policy will automatically be reinstated on the forty-fifth (45th) day following the date of the conditional receipt.

The reinstated policy shall cover losses resulting from such accidental injury as may be sustained after the date of reinstatement. The reinstated policy shall also cover specified diseases due to a Sickness as may begin more than ten (10) days after the reinstatement date. In all other respects, Your rights and Ours will remain the same, subject to any restrictions attached in connection with the reinstatement.

PART 6: TERMINATION OF COVERAGE PROVISION

TERMINATION OF AN INSURED PERSON'S COVERAGE: Coverage under this Policy will terminate on the earliest of:

(1) the date premiums are not received when due, subject to the Grace Period provision;
(2) the date You specify in Your written request for termination;
(3) the date an Insured Person dies;
(4) the date the reduced Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ is paid during the first thirty (30) days immediately following the Effective of the policy; or
(5) the date 100% of the Recurrence Benefit Amount is paid.

INSURED CHILD TERMINATION OF COVERAGE: An Insured Child shall cease to be covered on the premium due date on or next following the earlier of such Child's:

(1) nineteenth (19th) birthday; or twenty-sixth (26th) birthday if a full-time student; or
(2) date of marriage.

The coverage of an Insured Child will not terminate if the Child is both: (1) incapable of self-sustaining employment because of mental incapacity or physical handicap; and (2) currently dependent upon You for support and maintenance. At Our expense, You must provide proof of incapacity and dependency upon request. Then, coverage will continue for as long as Your insurance stays in force and such Child remains incapacitated.

INSURED SPOUSE TERMINATION OF COVERAGE: Your Spouse's coverage shall cease on the premium due date on or next following Our receipt of written notice of a valid judgment of dissolution of marriage, or legal separation and a copy of that order.

AT TERMINATION OF YOUR COVERAGE: When Your coverage terminates as a result of (1) Your death; (2) Your receipt of payment for the reduced Benefit Amount; or (3) Your receipt of payment for 100% of the Recurrence Benefit Amount the following will apply:

(1) If this is a policy that includes coverage for You and Your Spouse or You, Your Spouse and Child(ren), Your Spouse will become the Named Insured. Your Spouse must notify Us in writing within sixty (60) days after Your death to continue coverage; or
(2) If this is a policy that includes You and Your Child(ren), the coverage ceases for all Insured Persons.

It is Your responsibility to notify Us of any Dependent's loss of eligibility for coverage. Our acceptance of premium for any person for whom coverage has terminated will not extend coverage for such person. We will be responsible for only the refund of any unearned premium.

Termination of coverage because a person ceases to be an Insured Person is without prejudice to any claim originating prior to termination of coverage.

PART 7: CONVERSION PRIVILEGES PROVISION

CONVERSION PRIVILEGES: A policy of First Diagnosis Cancer (hereinafter called a Conversion Policy) may be applied for if coverage under this policy ends as set forth in the Insured Child Termination of Coverage provision or the Insured Spouse Termination of Coverage provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions.

(1) An application for the Conversion Policy and the first premium must be received by Us within thirty-one (31) days after the date on which the Insured Person's coverage under this policy ends.

(2) The premium for the Conversion Policy will be the premium payable on the Effective Date of the Conversion Policy for the form and amount of coverage provided.

(3) The Effective Date of the Conversion Policy will be the date coverage ends for the Insured Person under this policy.

(4) The Conversion Policy will not provide benefits greater than those provided to the Insured Person under this policy. The converted coverage will be as provided on a substantially similar or comparable policy form then being issued by Us.

(5) Any special provisions that apply to an Insured Person under this policy will also apply under the Conversion Policy.

PART 8: HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of a claim must be given to Us within ninety (90) days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us, with information sufficient to identify You, will be notice to Us.

CLAIM FORMS: When We receive notice of claim, if additional information is required, We will send You forms for filing proof of loss. If We fail to provide these forms within fifteen (15) days after receipt of notice of claim, We agree You will have met the requirements for filing proof of loss, within the time allowed.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of loss. Failure to provide written proof will not invalidate nor reduce any claim if it was not reasonably possible to send such proof within the time allowed, provided such proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will any claim be accepted later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon Our receipt of due written Proof of Loss.

PAYMENT OF CLAIMS: Unless otherwise assigned by You, all benefits payable under this policy will be payable to You during Your lifetime and, any accrued benefits unpaid at Your death will paid to the designated Beneficiary, if any, otherwise to Your estate. If benefits are payable to Your estate, We may pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PART 9: GENERAL INFORMATION

The provisions of the policy set out Your rights and obligations as a Named Insured and Our rights and obligations as Your insurance company.

ENTIRE CONTRACT: This policy, including the application, the riders, the endorsements, the amendments and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by an executive officer of the insurance company in writing. Such officer's approval must be endorsed hereon and attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of the two (2) year period.

No claim for loss incurred that starts after twelve (12) months from the Effective Date of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this policy.

CHANGE OF BENEFICIARY: Unless You make an irrevocable designation of Beneficiary, You reserve the right to change a Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be requisite to assignment of this policy, to any change of Beneficiary or Beneficiaries or to any other changes in this policy.

MISSTATEMENT OF AGE: If You or Your Spouse's age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. If according to the correct age, the coverage would not have become effective, Our liability shall be limited to the refund of all premiums paid for the period not covered.

CONFORMITY WITH STATE STATUTES AND/OR INSURANCE REGULATIONS: Any provision of this policy, which, on its Effective Date, is in conflict with the statutes, and/or insurance regulations of the State where You reside is hereby amended to conform to the minimum requirements of such statutes and/or regulations.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought to recover on this policy more than three (3) years after the time written Proof of Loss is required to be furnished.

PHYSICAL EXAMINATION AND AUTOPSY: We, at Our own expense, have the right and opportunity to examine any Insured Person when and as often as We may reasonably require during the pendency of a claim and to require an autopsy in case of death where it is not forbidden by law.

CANCELLATION: You may cancel this policy at any time by notifying Us. Your cancellation will be effective upon receipt of Your notice or on such later date as may be specified in such notice. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

REFUND OF UNEARNED PREMIUM: If an Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

Loyal American
Life Insurance Company®

[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS HEART AND STROKE INSURANCE POLICY

Here is Your new First Diagnosis Heart and Stroke Insurance Policy. The language used is easy to understand. Loyal American Life Insurance Company® will be referred to in this policy as "We", "Our", and "Us". "You" or "Your" means the Named Insured.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

RIGHT TO ADJUST FUTURE PREMIUMS. After this policy has been in force for twelve (12) months, We may change the premium rates only if We change them for all policies like Yours in Your state on a premium class basis. A premium class basis is determined by such factors as benefits, age, gender, geographic location, tobacco use and the year the policy is issued. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. If We change the premium rates for all policies of this form issued by Us and in force in Your state, We will inform You in writing at least thirty (30) days before the change occurs at the address shown in Our records.

PRE-EXISTING CONDITION(S). The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s).

IMPORTANT NOTICE! PLEASE READ. Please read the copy of the application attached to this policy. The best time to clear up any questions is now, before a claim arises. Omissions or misstatements in the application could cause an otherwise valid claim to be denied or coverage to be rescinded. Carefully check the application and write to Loyal American Life Insurance Company at [P.O. Box 559004, Austin, Texas 78755-9004] within ten (10) days if any information shown on it is not correct and complete or if any medical history has been left out. The application is a part of this policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

YOU HAVE THE RIGHT TO EXAMINE THIS POLICY FOR THIRTY (30) DAYS. Please read Your policy carefully. If You are not satisfied with Your policy for any reason, You may return the policy to Us. It must be returned within thirty (30) days from receipt of this policy. If returned, the policy will be void from its beginning as though the policy was never issued. Any premium paid on this policy will be refunded.

NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY. THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

[Brenda Hardison]
Secretary

[ ]
President

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PART 1: DEFINITIONS

When We use the following words, this is what We mean:

BENEFICIARY means the person(s) You named in the application, or by later designation, to receive any death benefit or accrued benefits unpaid at Your death.

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

CHILD(REN) means Your natural child, stepchild, legally adopted child, a child placed with You for adoption, a foster child, or court appointed guardianship/order/administrative order for a child including grandchild, who is:

(1) insurable and named on the application;
(2) unmarried;
(3) chiefly dependent on You or Your Spouse for support; and
(4) has not attained the limiting age of nineteen (19) or twenty-six (26) if enrolled as a full-time student in an accredited school or college.

Child(ren) also includes dependent child(ren), regardless of age, who:

(1) are mentally or physically handicapped;
(2) became or become handicapped prior to the limiting Age; and
(3) cannot support themselves because of their handicap.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this policy, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records.

DEPENDENTS means Your Spouse and Child(ren) as defined under this section.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of a Qualifying Event through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this policy.

FIRST EVER DIAGNOSIS OR PROCEDURE means the Diagnosis or procedure is the first time ever in the Insured Person's lifetime they have undergone that specific covered procedure or been Diagnosed with that specific disease or condition.

IMMEDIATE FAMILY means anyone related to an Insured Person in the following manner: the Spouse, father (including stepfather), mother (including stepmother), sons (including stepsons), daughters (including stepdaughter), brothers or sisters (including stepbrothers or stepsisters), grandchildren, or father-in-law or mother-in-law of any Insured Person.

INSURED PERSON means the person(s) named in the policy application or subsequently added and who were approved for coverage by Us until death, lapse of coverage due to non-payment of premiums, cancellation of policy upon the Named Insured's request, or under the Termination of Coverage and Conversion Privileges Provisions.

NAMED INSURED means the primary person accepted for coverage by Us, who is described in the application and has completed and signed the application.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the policy.

QUALIFYING EVENTS means one (1) of the diseases, conditions or procedures listed below for which benefits may be payable.

ANGIOPLASTY means reconstitution or recanalization of a blood vessel. It may involve balloon dilation, mechanical stripping of intima, or forceful injection of fibrinolytics. The procedure must be performed by a Physician who is a board certified cardiologist. Placement of a stent or other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

AORTIC SURGERY means undergoing surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be performed by a Physician who is a board certified cardiologist, cardiovascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

CORONARY ARTERY BYPASS SURGERY means open heart surgery to correct narrowing or blockage of one (1) or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, or other nonsurgical procedures. This surgery requires placement of the patient on a cardiac-pulmonary bypass machine and must be performed by a Physician who is a board certified cardiothoracic surgeon. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

HEART ATTACK means the myocardial infarction, coronary thrombosis or coronary occlusion that is Diagnosed or treated after the policy Effective Date. The following are not considered as a Heart Attack: congestive heart failure, atherosclerotic heart disease, an EKG change consistent with transient ischemic change, angina, chance finding of EKG changes suggestive of a previous Heart Attack, coronary artery disease or any other dysfunction of the cardiovascular system, or death of the heart muscle coincident with death of an Insured Person from other causes. Diagnosis of a Heart Attack must be positively made by a Physician who is board certified and be based on **all** of the following criteria:

(1) associated new EKG changes consistent with injury;
(2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
(3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

HEART TRANSPLANT means a surgery in which an Insured Person receives, from a suitable donor and in accordance with generally accepted medical procedures, as a result of a surgical transplant, a heart, heart-lung or other combination transplant including heart. In order for the transplant to be covered under this policy, the Insured Person must be registered by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). **It does not include transplants involving mechanical or non-human organs.**

HEART VALVE REPLACEMENT/REPAIR SURGERY means undergoing open heart surgery to replace or repair one (1) or more valves. The surgery must be performed by a Physician who is a board certified cardiologist or cardiovascular surgeon.

STENTS means the surgical placement of a stent for the purpose of correcting narrowing or blockage of one (1) or more coronary arteries caused by heart disease.

STROKE means an acute cerebral vascular accident (due to rupture or acute occlusion of a cerebral artery) producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit, positively Diagnosed by a Physician, persisting for at least thirty (30) days. This definition of stroke shall specifically exclude Transient Ischemic Attacks, attacks of Vertebrobasilar Ischemia, head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits. The Diagnosis must be made by a Physician who is a board certified neurologist.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this policy is in force.

SPOUSE means the person who is lawfully married and named on the application as the Spouse to be insured at the time You first applied for this coverage, or who was added at a later date. There may never be more than one (1) Spouse insured at any given time.

PART 2: ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

AT THE TIME THE POLICY IS ISSUED: Before coverage becomes effective for each Insured Person:
(1) You must apply;
(2) We must approve Your application; and
(3) You must pay the required premium.

Applicants must be acceptable to Us based on Our underwriting rules in effect at the time of application to become an Insured Person. The effective date of insurance for each such person will be the Effective Date shown on the Policy Schedule Page.

PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE: Eligible Dependents not covered under the policy when the policy is issued may be added later. To do so, We must receive:
(1) a new application for each Dependent;
(2) evidence satisfactory to Us that such Dependent is eligible and insurable according to Our underwriting guidelines; and
(3) payment of the additional required premium.

The Effective Date of coverage for the added Insured Person will be the later of the date on which We approve the application or the date upon which We receive any additional required premium.

COVERAGE OF NEWBORN OR ADOPTED CHILD(REN): Any Child born to You while this policy is in force is automatically covered from the moment of birth for ninety (90) days or until the next premium due date, whichever is later. For coverage to continue We must receive notice (which must include the Child's name, gender and date of birth) within ninety (90) days of such Child's birth or before the next premium due date, whichever is later, and You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notice.

Any Child who is under Your charge, care, and control and whom You have filed a petition to adopt is automatically covered for sixty (60) days from the date of the filing of a petition for adoption. In the case of a newborn, the coverage shall be from the moment of birth if the petition is filed within sixty (60) days after the birth of such Child. For coverage to continue We must receive notice (which must include the Child's name, gender, date of birth and date of the filing of a petition for adoption) within sixty (60) days from the date of the filing of a petition for adoption and You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notice.

The Effective Date of coverage for the added newborn or adopted Child(ren) will be the date of birth for a newborn Child or the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the Child.

PART 3: BENEFITS PROVIDED BY THIS POLICY

FIRST DIAGNOSIS HEART AND STROKE BENEFIT: We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

(1) The First Ever Diagnosis or Procedure must be made and performed within the United States; and
(2) the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this policy; and
(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this policy. Payment of benefits is subject to all terms and conditions of this policy.

PART 4: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy for:

(1) any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
(2) intentionally self-inflicted injury or Sickness;
(3) suicide or attempted suicide, while sane or insane;
(4) loss that begins prior to the Effective Date of coverage;
(5) Diagnosis and treatment received outside the United States or its territories;
(6) any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
(7) any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this policy.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 5: PREMIUM PAYMENTS AND REINSTATEMENT

INITIAL: This policy is issued based on the application, Our underwriting requirements and payment of the initial premium. The policy begins on the Effective Date shown on the Policy Schedule Page. All periods of insurance will begin and end at 12:01 a.m., at the place where You live.

RENEWAL: All renewal premiums must be paid in consecutive terms. They shall be paid by modes currently offered by Us. Renewal premiums are payable to Us. Premiums must be paid on or before the date due or before the end of the grace period. If this policy should lapse, the payment of a premium will reinstate this policy only as provided in the reinstatement provision in this section.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium, falling due after the first premium. This policy will continue in force during the grace period. If the premium due is not paid during the grace period, the policy will terminate coverage at the end of the period for which premiums were paid.

LAPSE AND REINSTATEMENT: If the renewal premium is not paid within the grace period, this policy will terminate on the first premium due date for which premium was not paid. If the policy terminates, Our acceptance of a premium payment without requiring an application for reinstatement will reinstate this policy. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

If We require an application for reinstatement and issue a conditional receipt, this policy will be reinstated upon Our approval of the reinstatement application. If We do not notify You in writing of Our prior approval or disapproval, this policy will automatically be reinstated on the forty-fifth (45^{th}) day following the date of the conditional receipt.

The reinstated policy shall cover losses resulting from such accidental injury as may be sustained after the date of reinstatement. The reinstated policy shall also cover specified diseases due to a Sickness as may begin more than ten (10) days after the reinstatement date. In all other respects, Your rights and Ours will remain the same, subject to any restrictions attached in connection with the reinstatement.

PART 6: TERMINATION OF COVERAGE PROVISION

TERMINATION OF AN INSURED PERSON'S COVERAGE: Coverage under this Policy will terminate on the earliest of:

(1) the date premiums are not received when due, subject to the Grace Period provision;
(2) the date You specify in Your written request for termination;
(3) the date an Insured Person dies; or
(4) the date 100% of the First Diagnosis Heart and Stroke Benefit Amount is paid.

INSURED CHILD TERMINATION OF COVERAGE: An Insured Child shall cease to be covered on the premium due date on or next following the earlier of such Child's:

(1) nineteenth (19th) birthday; or twenty-sixth (26th) birthday if a full-time student; or
(2) date of marriage.

The coverage of an Insured Child will not terminate if the Child is both: (1) incapable of self-sustaining employment because of mental incapacity or physical handicap; and (2) currently dependent upon You for support and maintenance. At Our expense, You must provide proof of incapacity and dependency upon request. Then, coverage will continue for as long as Your insurance stays in force and such Child remains incapacitated.

INSURED SPOUSE TERMINATION OF COVERAGE: Your Spouse's coverage shall cease on the premium due date on or next following Our receipt of written notice of a valid judgment of dissolution of marriage, or legal separation and a copy of that order.

AT TERMINATION OF YOUR COVERAGE: When Your coverage terminates as a result of (1) Your death; or (2) Your receipt of payment for 100% of the First Diagnosis Heart and Stroke Benefit Amount the following will apply:

(1) If this is a policy that includes coverage for You and Your Spouse or You, Your Spouse and Child(ren), Your Spouse will become the Named Insured. Your Spouse must notify Us in writing within sixty (60) days after Your death to continue coverage; or
(2) If this is a policy that includes You and Your Child(ren), the coverage ceases for all Insured Persons.

It is Your responsibility to notify Us of any Dependent's loss of eligibility for coverage. Our acceptance of premium for any person for whom coverage has terminated will not extend coverage for such person. We will be responsible for only the refund of any unearned premium.

Termination of coverage because a person ceases to be an Insured Person is without prejudice to any claim originating prior to termination of coverage.

PART 7: CONVERSION PRIVILEGES PROVISION

CONVERSION PRIVILEGES: A policy of First Diagnosis Heart and Stroke (hereinafter called a Conversion Policy) may be applied for if coverage under this policy ends as set forth in the Insured Child Termination of Coverage provision or the Insured Spouse Termination of Coverage provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions:

(1) An application for the Conversion Policy and the first premium must be received by Us within thirty-one (31) days after the date on which the Insured Person's coverage under this policy ends.

(2) The premium for the Conversion Policy will be the premium payable on the Effective Date of the Conversion Policy for the form and amount of coverage provided.

(3) The Effective Date of the Conversion Policy will be the date coverage ends for the Insured Person under this policy.

(4) The Conversion Policy will not provide benefits greater than those provided to the Insured Person under this policy. The converted coverage will be as provided on a substantially similar or comparable policy form then being issued by Us.

(5) Any special provisions that apply to an Insured Person under this policy will also apply under the Conversion Policy.

PART 8: HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of a claim must be given to Us within ninety (90) days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us, with information sufficient to identify You, will be notice to Us.

CLAIM FORMS: When We receive notice of claim, if additional information is required, We will send You forms for filing proof of loss. If We fail to provide these forms within fifteen (15) days after receipt of notice of claim, We agree You will have met the requirements for filing proof of loss, within the time allowed.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of loss. Failure to provide written proof will not invalidate nor reduce any claim if it was not reasonably possible to send such proof within the time allowed, provided such proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will any claim be accepted later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon Our receipt of due written Proof of Loss.

PAYMENT OF CLAIMS: Unless otherwise assigned by You, all benefits payable under this policy will be payable to You during Your lifetime and, any accrued benefits unpaid at Your death will paid to the designated Beneficiary, if any, otherwise to Your estate. If benefits are payable to Your estate, We may pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PART 9: GENERAL INFORMATION

The provisions of the policy set out Your rights and obligations as a Named Insured and Our rights and obligations as Your insurance company.

ENTIRE CONTRACT: This policy, including the application, the riders, the endorsements, the amendments and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by an executive officer of the insurance company in writing. Such officer's approval must be endorsed hereon and attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of the two (2) year period.

No claim for loss incurred that starts after twelve (12) months from the Effective Date of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this policy.

CHANGE OF BENEFICIARY: Unless You make an irrevocable designation of Beneficiary, You reserve the right to change a Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be requisite to assignment of this policy, to any change of Beneficiary or Beneficiaries or to any other changes in this policy.

MISSTATEMENT OF AGE: If You or Your Spouse's age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. If according to the correct age, the coverage would not have become effective, Our liability shall be limited to the refund of all premiums paid for the period not covered.

CONFORMITY WITH STATE STATUTES AND/OR INSURANCE REGULATIONS: Any provision of this policy, which, on its Effective Date, is in conflict with the statutes, and/or insurance regulations of the State where You reside is hereby amended to conform to the minimum requirements of such statutes and/or regulations.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought to recover on this policy more than three (3) years after the time written Proof of Loss is required to be furnished.

PHYSICAL EXAMINATION AND AUTOPSY: We, at Our own expense, have the right and opportunity to examine any Insured Person when and as often as We may reasonably require during the pendency of a claim and to require an autopsy in case of death where it is not forbidden by law.

CANCELLATION: You may cancel this policy at any time by notifying Us. Your cancellation will be effective upon receipt of Your notice or on such later date as may be specified in such notice. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

REFUND OF UNEARNED PREMIUM: If an Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS CANCER BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Policy Schedule Page, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

ADVICE OR TREATMENT means care or services provided by a Physician or other member of the medical profession, acting within the scope of their license, including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition, "Advice or Treatment" does not include Maintenance Drug Therapy or routine follow-up visits to verify if Cancer or Carcinoma in Situ has returned.

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

CANCER means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Blood cancers such as Leukemia, Myelodysplastic Syndrome (MDS) and lymphoma are included. Cancer must be Diagnosed pursuant to a Pathological or Clinical Diagnosis.

While not an exhaustive list, the following premalignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this rider:
(1) pre-malignant lesions (such as intraepithelial neoplasia);
(2) benign tumors or polyps;
(3) early prostate cancer Diagnosed as T1N0M0 or equivalent staging;
(4) Carcinoma in Situ; or
(5) any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

CARCINOMA IN SITU means a Diagnosis of Cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ must be Diagnosed pursuant to a Pathological or Clinical Diagnosis. Carcinoma in Situ includes, but is not limited to:
(1) early prostate cancer Diagnosed as T1N0M0 or equivalent staging; and
(2) melanoma not invading the dermis.

Carcinoma in Situ does not include:
(1) other skin malignancies;
(2) pre-malignant lesions (such as intraepithelial neoplasia); or
(3) benign tumors or polyps.

CLINICAL DIAGNOSIS means the Diagnosis of Cancer or Carcinoma in Situ based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer or Carcinoma in Situ only if the following conditions are met:

(1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
(2) there is medical evidence to support the Diagnosis; and
(3) a Physician is treating the Insured Person for Cancer and/or Carcinoma in Situ.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this rider, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records. This includes recurrence of a previously Diagnosed Cancer provided the Insured Person has not received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

DIAGNOSIS and DIAGNOSED mean the definitive establishment of Cancer or Carcinoma in Situ through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this rider.

FIRST EVER DIAGNOSIS means the Diagnosis is the first time ever in the Insured Person's lifetime they have been Diagnosed with Cancer or Carcinoma in Situ.

MAINTENANCE DRUG THERAPY means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of Cancer due to primary treatment. It is meant to decrease the risk of Cancer recurrence rather than the palliative or suppression of Cancer that is still present.

PATHOLOGICAL DIAGNOSIS means a Diagnosis of Cancer or Carcinoma in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this rider. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical Advice or Treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the rider.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this rider is in force.

SKIN CANCER means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, mycosis fungoides or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.

PART 2: BENEFITS PROVIDED BY THIS RIDER

FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured Person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

(1) 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
(2) the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

(1) Diagnosis must be made within the United States; and
(2) the Date of Diagnosis shall occur while the Insured Person is covered by this rider; and
(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the rider. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this rider's Effective Date, coverage for the Insured Person under the this rider will end.

PART 3: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

(1) any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
(2) loss that begins prior to the Effective Date of coverage;
(3) Diagnosis and treatment received outside the United States or its territories; or
(4) any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 4: TERMINATION PROVISIONS

This rider terminates on the earliest of the following:

(1) the date the policy terminates;
(2) the date premiums are not received when due, subject to the Grace Period provision; or
(3) the date specified in Your advance written request to terminate this rider.

Coverage for an Insured Person will terminate under this rider on the earliest of:

(1) the date an Insured Person dies;
(2) the date the reduced Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ is paid during the first thirty (30) days immediately following the Effective Date of this rider; or
(3) the date 100% of the Recurrence Benefit Amount is paid.

This rider will continue to provide coverage for the other Insured Person(s), if any, until the coverage on the last Insured Person terminates.

PART 5: REINSTATEMENT

If You apply for reinstatement or conversion of the policy, You may apply to reinstate or convert this rider at the same time.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison] SECRETARY

[ ] PRESIDENT

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS HEART AND STROKE BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Policy Schedule Page, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this rider, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of a Qualifying Event through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this rider.

FIRST EVER DIAGNOSIS OR PROCEDURE means the Diagnosis or procedure is the first time ever in the Insured Person's lifetime they have undergone that specific covered procedure or been Diagnosed with that specific disease or condition.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this rider. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the rider.

QUALIFYING EVENTS means one (1) of the diseases, conditions or procedures listed below for which benefits may be payable.

> **ANGIOPLASTY** means reconstitution or recanalization of a blood vessel. It may involve balloon dilation, mechanical stripping of intima or forceful injection of fibrinolytics. The procedure must be performed by a Physician who is a board certified cardiologist. Placement of a Stent or other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

AORTIC SURGERY means undergoing surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be performed by a Physician who is a board certified cardiologist, cardiovascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

CORONARY ARTERY BYPASS SURGERY means open heart surgery, to correct narrowing or blockage of one (1) or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, or other nonsurgical procedures. This surgery requires placement of the patient on a cardiac-pulmonary bypass machine and must be performed by a Physician who is a board certified cardiothoracic surgeon. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

HEART ATTACK means the myocardial infarction, coronary thrombosis or coronary occlusion that is Diagnosed or treated after the rider Effective Date. The following are not considered as a Heart Attack: congestive heart failure, atherosclerotic heart disease, an EKG change consistent with transient ischemic change, angina, chance finding of EKG changes suggestive of a previous Heart Attack, coronary artery disease or any other dysfunction of the cardiovascular system, or death of the heart muscle coincident with death of an Insured Person from other causes. Diagnosis of a Heart Attack must be positively made by a Physician who is board certified and be based on **all** of the following criteria:

(1) associated new EKG changes consistent with injury;
(2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
(3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

HEART TRANSPLANT means a surgery in which an Insured Person receives, from a suitable donor and in accordance with generally accepted medical procedures, as a result of a surgical transplant, a heart, heart-lung or other combination transplant including heart. In order for the transplant to be covered under this rider, the Insured Person must be registered by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). **It does not include transplants involving mechanical or non-human organs.**

HEART VALVE REPLACEMENT/REPAIR SURGERY means undergoing open heart surgery to replace or repair one (1) or more valves. The surgery must be performed by a Physician who is a board certified cardiologist or cardiovascular surgeon.

STENTS means the surgical placement of a stent for the purpose of correcting narrowing or blockage of one (1) or more coronary arteries caused by heart disease.

STROKE means an acute cerebral vascular accident (due to rupture or acute occlusion of a cerebral artery) producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit, positively Diagnosed by a Physician, persisting for at least thirty (30) days. This definition of stroke shall specifically exclude Transient Ischemic Attacks, attacks of Vertebrobasilar Ischemia, head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits. The Diagnosis must be made by a Physician who is a board certified neurologist.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this rider is in force.

PART 2: BENEFITS PROVIDED BY THIS RIDER

FIRST DIAGNOSIS HEART AND STROKE BENEFIT: We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

(1) The First Ever Diagnosis or Procedure must be made and performed within the United States; and
(2) the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this rider; and
(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

* We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this rider. Payment of benefits is subject to all terms and conditions of this rider and the policy to which it is attached.

PART 3: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

(1) any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
(2) intentionally self-inflicted injury or Sickness;
(3) suicide or attempted suicide, while sane or insane;
(4) loss that begins prior to the Effective Date of coverage;
(5) Diagnosis and treatment received outside the United States or its territories;
(6) any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
(7) any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this rider.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 4: TERMINATION PROVISIONS

This rider terminates on the earliest of the following:

(1) the date the policy terminates;
(2) the date premiums are not received when due, subject to the Grace Period provision; or
(3) the date specified in Your advance written request to terminate this rider.

Coverage for an Insured Person will terminate under this rider on the earliest of:

(1) the date an Insured Person dies; or
(2) the date 100% of the First Diagnosis Heart and Stroke Benefit Amount is paid.

This rider will continue to provide coverage for the other Insured Person(s), if any, until the coverage on the last Insured Person terminates.

PART 5: REINSTATEMENT

If You apply for reinstatement or conversion of the policy, You may apply to reinstate or convert this rider at the same time.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison] SECRETARY

[ ] PRESIDENT

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SPECIFIED DISEASE BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Policy Schedule Page, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

AMYOTROPHIC LATERAL SCLEROSIS (ALS) means a progressive degenerative motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to degeneration of anterior horn cells of the spinal cord and cranial nerves. ALS must be Diagnosed by a Physician who is a board certified neurologist based on generally acceptable principles of medicine.

BENEFIT AMOUNT means the amount We will pay for a Specified Disease as shown on the Policy Schedule Page.

COMA means a Diagnosis that the Insured Person is in a state of unconsciousness from which the Insured Person cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least ninety-six (96) hours. The Diagnosis of a Coma must be made by a Physician who is a board certified neurologist.

DATE OF DIAGNOSIS OR PROCEDURE means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this rider, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records. For a procedure, it is the date the Insured Person undergoes the procedure.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of the Specified Disease through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this rider.

END STAGE RENAL FAILURE means chronic irreversible failure of both kidneys to function requiring an Insured Person to undergo regular hemodialysis or peritoneal dialysis at least weekly. The Diagnosis of End Stage Renal Failure must be made by a Physician who is a board certified nephrologist.

FIRST EVER DIAGNOSIS OR PROCEDURE means the Diagnosis or procedure is the first time ever in the Insured Person's lifetime they have undergone that specific covered procedure or been Diagnosed with that specific Specified Disease.

INJURY means accidental bodily damage sustained by the Insured Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs unexpectedly and while coverage under this rider is in force.

MAJOR ORGAN TRANSPLANT means a surgery in which an Insured Person receives, from a suitable donor and in accordance with generally accepted medical procedures, as a result of a surgical transplant, one (1) or more of the following organs: liver, kidney, heart, lung, or pancreas. In order for the Major Organ Transplant to be covered under this rider, the Insured Person must be registered by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). **It does not include transplants involving mechanical or non-human organs.**

MULTIPLE SCLEROSIS (MS) means the occurrence of at least two (2) episodes of well-defined neurological abnormalities, with objective evidence of lesions at more than one (1) site within the central nervous system which have no other etiology. MS must be Diagnosed by a Physician who is a board certified neurologist based on generally acceptable principles of medicine, and must be supported by modern imaging and/or investigative techniques.

PARALYSIS means spinal cord Injuries occurring after the rider Effective Date resulting in permanent, complete, total and irreversible loss of use of two (2) or more limbs (paraplegia or quadriplegia) for a continuous period of at least thirty (30) days. Paralysis must be positively Diagnosed by a Physician who is a board certified neurologist. Limb is defined as a complete arm or leg.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this rider. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the rider.

SEVERE BURNS means a Diagnosis that the Insured Person has sustained third degree burns covering at least 20% of the surface area of the body. The Diagnosis must be made by a Physician who is board certified as a General Surgeon or Plastic Surgeon.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this rider is in force.

SPECIFIED DISEASE means those conditions specified within this rider for which benefits may be payable.

PART 2: BENEFITS PROVIDED BY THIS RIDER

SPECIFIED DISEASE BENEFIT: We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

(1) Diagnosis must be made within the United States; and
(2) the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this rider.

Specified Diseases
Amyotrophic Lateral Sclerosis (ALS)
Coma
End Stage Renal Failure
Major Organ Transplant
Multiple Sclerosis (MS)
Paralysis
Severe Burns

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this rider for the same Insured Person.

If the Date of Diagnosis or Procedure of two (2) or more Specified Diseases is the same day, We will pay only one (1) Specified Disease benefit.

No benefits are payable for conditions other than the Specified Diseases defined in this rider. Payment of the Specified Disease benefit is subject to all terms and conditions of this rider and the policy to which it is attached.

PART 3: EXCLUSIONS AND LIMITATIONS

This Rider does not cover any disease, Sickness, incapacity or procedure other than the Specified Diseases defined above, even though another disease or incapacity may have been complicated, aggravated or directly affected by the Specified Disease or its treatment.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for any Sickness or Injury resulting, whether directly or indirectly, from any of the following:

(1) intentionally self-inflicted Sickness or Injury;
(2) suicide or attempted suicide, while sane or insane;
(3) loss that begins prior to the Effective Date of coverage;
(4) care and treatment received outside the United States or its territories;
(5) an act of declared or undeclared war;
(6) an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
(7) committing or attempting to commit a felony or engaging in an illegal occupation or activity;
(8) participation in any sport or sporting activity for wage, compensation or profit;
(9) operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
(10) engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
(11) riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
(12) any illness specifically excluded from the definition of any Specified Disease.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 4: TERMINATION PROVISIONS

This rider terminates on the earliest of the following:
(1) the date the policy terminates;
(2) the date premiums are not received when due, subject to the Grace Period provision; or
(3) the date specified in Your advance written request to terminate this rider.

If an Insured Person receives 100% of their Benefit Amount from this rider or dies, coverage for that Insured Person under this rider will be terminated. This rider will continue to provide coverage for the other Insured Person(s), if any, until the coverage on the last Insured Person terminates.

PART 5: REINSTATEMENT

If You apply for reinstatement or conversion of the policy, You may apply to reinstate or convert this rider at the same time.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison]

SECRETARY

[ ]

PRESIDENT

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

RETURN OF PREMIUM RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the policy schedule, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

CLAIMS PAID means the total amount of Claims Paid for the policy and any other attached riders on or after the Effective Date of this Return of Premium Rider.

ORIGINAL NAMED INSURED means the Named Insured on the Effective Date of this rider.

ORIGINAL PREMIUM means the total amount of premiums received by the Company that You paid for this rider, the policy, the annual policy fee, if applicable, and any other attached benefit riders as of the Rider Effective Date. The Original Premium calculation considers the total amount of premium in effect on the Rider Effective Date and will not include premium increases or benefit increases that may occur for the policy or other such riders after the Rider Effective Date. Original Premium will be adjusted for any benefit decreases that may occur for the policy or other such riders on or after the Rider Effective Date.

RIDER EFFECTIVE DATE means the effective date of this Return of Premium Rider.

PART 2: BENEFITS PROVIDED BY THIS RIDER

In the event You die while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

(1) Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
(2) Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
(3) Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.

PART 3: CLAIMS PROVISIONS

PROOF OF DEATH: Any benefits payable under the terms of this rider will be paid when we receive completed proof of claim forms along with a certified copy of the Original Named Insured's death certificate. Such proof should be sent to Us within ninety (90) days of the date of death. In no event will such proof be accepted later than one (1) year from the date of death. Claim forms will be made available to Your named Beneficiary or estate upon request.

BENEFIT PAYMENT: Any benefit due will be paid in one lump sum within ninety (90) days of our receipt of due written Proof of Death. Benefits will be paid according to any Beneficiary designation in effect at time of payment. If none is then in effect, We will pay benefits to Your estate.

PART 4: TERMINATION PROVISIONS

This rider will terminate on the earlier of:

(1) payment of the return of premium benefit;
(2) failure to pay the premium for this rider (it is not eligible for reinstatement); or
(3) coverage terminates for the Original Named Insured.

PART 5: ADDITIONAL PROVISIONS

This rider cannot be converted.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison]

SECRETARY

[ ]

PRESIDENT

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

RETURN OF PREMIUM (85) RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the policy schedule, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

CLAIMS PAID means the total amount of Claims Paid for the policy and any other attached riders on or after the Effective Date of this Return of Premium (85) Rider.

ORIGINAL NAMED INSURED means the Named Insured on the Effective Date of this rider.

ORIGINAL PREMIUM means the total amount of premiums received by the Company that You paid for this rider, the policy, the annual policy fee, if applicable, and any other attached benefit riders as of the Rider Effective Date. The Original Premium calculation considers the total amount of premium in effect on the Rider Effective Date and will not include premium increases or benefit increases that may occur for the policy or other such riders after the Rider Effective Date. Original Premium will be adjusted for any benefit decreases that may occur for the policy or other such riders on or after the Rider Effective Date.

RIDER EFFECTIVE DATE means the effective date of this Return of Premium (85) Rider.

PART 2: BENEFITS PROVIDED BY THIS RIDER

In the event You die prior to Your eighty-sixth (86th) birthday while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

(1) Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
(2) Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
(3) Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.

PART 3: CLAIMS PROVISIONS

PROOF OF DEATH: Any benefits payable under the terms of this rider will be paid when we receive completed proof of claim forms along with a certified copy of the Original Named Insured's death certificate. Such proof should be sent to Us within ninety (90) days of the date of death. In no event will such proof be accepted later than one (1) year from the date of death. Claim forms will be made available to Your named Beneficiary or estate upon request.

BENEFIT PAYMENT: Any benefit due will be paid in one lump sum within ninety (90) days of our receipt of due written Proof of Death. Benefits will be paid according to any Beneficiary designation in effect at time of payment. If none is then in effect, We will pay benefits to Your estate.

PART 4: TERMINATION PROVISIONS

This rider will terminate on the earlier of:

(1) payment of the return of premium benefit;
(2) the original Named Insured's attainment of age eighty-six (86);
(3) failure to pay the premium for this rider (it is not eligible for reinstatement);
(4) coverage terminates for the Original Named Insured; or
(5) when the total amount of claims paid exceeds the amount of the return of premium benefit.

PART 5: ADDITIONAL PROVISIONS

This rider cannot be converted.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison]

SECRETARY

[ ]

PRESIDENT

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

RETURN OF PREMIUM UPON TERMINATION (20 YEARS) RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the policy schedule, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

CLAIMS PAID means the total amount of Claims Paid for the policy and any other attached riders on or after the Effective Date of this Return of Premium Upon Termination (20 Years) Rider.

ORIGINAL NAMED INSURED means the Named Insured on the Effective Date of this rider.

ORIGINAL PREMIUM means the total amount of premiums received by the Company that You paid for this rider, the policy, the annual policy fee, if applicable, and any other attached benefit riders as of the Rider Effective Date. The Original Premium calculation considers the total amount of premium in effect on the Rider Effective Date and will not include premium increases or benefit increases that may occur for the policy or other such riders after the Rider Effective Date. Original Premium will be adjusted for any benefit decreases that may occur for the policy or other such riders on or after the Rider Effective Date.

RIDER EFFECTIVE DATE means the effective date of this Return of Premium Upon Termination (20 Years) Rider.

PART 2: BENEFITS PROVIDED BY THIS RIDER

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for twenty (20) consecutive years beginning with the Rider Effective Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

(1) Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
(2) Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
(3) Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.

PART 3: TERMINATION PROVISIONS

This rider will terminate on the earlier of:

(1) payment of the return of premium benefit;
(2) failure to pay the premium for this rider (it is not eligible for reinstatement); or
(3) coverage terminates for the original Named Insured.

PART 4: ADDITIONAL PROVISIONS

This rider cannot be converted.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison]

SECRETARY

[ ]

PRESIDENT

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

RETURN OF PREMIUM UPON TERMINATION (15 YEARS) RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the policy schedule, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

CLAIMS PAID means the total amount of Claims Paid for the policy and any other attached riders on or after the Effective Date of this Return of Premium Upon Termination (15 Years) Rider.

ORIGINAL NAMED INSURED means the Named Insured on the Effective Date of this rider.

ORIGINAL PREMIUM means the total amount of premiums received by the Company that You paid for this rider, the policy, the annual policy fee, if applicable, and any other attached benefit riders as of the Rider Effective Date. The Original Premium calculation considers the total amount of premium in effect on the Rider Effective Date and will not include premium increases or benefit increases that may occur for the policy or other such riders after the Rider Effective Date. Original Premium will be adjusted for any benefit decreases that may occur for the policy or other such riders on or after the Rider Effective Date.

RIDER EFFECTIVE DATE means the effective date of this Return of Premium Upon Termination (15 Years) Rider.

PART 2: BENEFITS PROVIDED BY THIS RIDER

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for fifteen (15) consecutive years beginning with the Rider Effective Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

(1) Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
(2) Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
(3) Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.

PART 3: TERMINATION PROVISIONS

This rider will terminate on the earlier of:

(1) payment of the return of premium benefit;
(2) failure to pay the premium for this rider (it is not eligible for reinstatement); or
(3) coverage terminates for the Original Named Insured.

PART 4: ADDITIONAL PROVISIONS

This rider cannot be converted.

Signed for Loyal American Life Insurance Company® at its office in Austin, Texas.

[Brenda Hardison]

SECRETARY

[ ]

PRESIDENT

LOYAL AMERICAN LIFE INSURANCE COMPANY
FIRST DIAGNOSIS CANCER INSURANCE POLICY SCHEDULE PAGE

POLICY NUMBER: [AC0001000C]

[EFFECTIVE DATE: [MAY 1, 2011]]

NAMED INSURED: [JOHN DOE]

SPOUSE: [JANE DOE]

CHILDREN: [JOHN DOE, JR], [CHRISTINE DOE]

STATE OF ISSUE: [ARKANSAS]

PREMIUMS

[MONTHLY]
[P.A.C.]
[$ XXX.XX]

[THE FIRST PREMIUM INCLUDES A ONE TIME ENROLLMENT FEE OF [$0.00 - $30.00]]

BENEFIT SCHEDULE PER INSURED PERSON

FIRST DIAGNOSIS CANCER BENEFIT AMOUNT:

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]

Reduced Benefits for Cancer and Carcinoma in Situ diagnosed during the first 30 days.

- Cancer: 10% of the Benefit Amount shown above.
- Carcinoma in Situ: 2.5% of the Benefit Amount Shown above.

OPTIONAL RIDERS:

[FIRST DIAGNOSIS HEART AND STROKE BENEFIT RIDER

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]]

[SPECIFIED DISEASE BENEFIT RIDER

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER

Benefit Amount:

[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$25,000]

In the Event of Loss of:	**The Amount Payable Will Be:**
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount
Overall Lifetime Maximum	100% of the Benefit Amount]]

[RETURN OF PREMIUM RIDER]

[RETURN OF PREMIUM (85) RIDER]

[RETURN OF PREMIUM UPON TERMINATION (15 YEARS) RIDER]

[RETURN OF PREMIUM UPON TERMINATION (20 YEARS) RIDER]

LOYAL AMERICAN LIFE INSURANCE COMPANY
FIRST DIAGNOSIS HEART AND STROKE INSURANCE POLICY SCHEDULE PAGE

POLICY NUMBER: [AC0001000C]

[EFFECTIVE DATE: [MAY 1, 2011]]

NAMED INSURED: [JOHN DOE]

SPOUSE: [JANE DOE]

CHILDREN: [JOHN DOE, JR], [CHRISTINE DOE]

STATE OF ISSUE: [ARKANSAS]

PREMIUMS

[MONTHLY]
[P.A.C.]
[$ XXX.XX]

[THE FIRST PREMIUM INCLUDES A ONE TIME ENROLLMENT FEE OF [$0.00 - $40.00]]

BENEFIT SCHEDULE PER INSURED PERSON

FIRST DIAGNOSIS HEART AND STROKE BENEFIT AMOUNT:

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]

OPTIONAL RIDERS:

[**FIRST DIAGNOSIS CANCER BENEFIT RIDER**

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]]

[SPECIFIED DISEASE BENEFIT RIDER

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$10,000]]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER

Benefit Amount:	
[JOHN DOE]	[$50,000]
[JANE DOE]	[$50,000]
[CHILDREN]	[$25,000]

In the Event of Loss of:	**The Amount Payable Will Be:**
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount
Overall Lifetime Maximum	100% of the Benefit Amount]]

[RETURN OF PREMIUM RIDER]

[RETURN OF PREMIUM (85) RIDER]

[RETURN OF PREMIUM UPON TERMINATION (15 YEARS) RIDER]

[RETURN OF PREMIUM UPON TERMINATION (20 YEARS) RIDER]

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[P.O. Box 559004, Austin, TX 78755-9004]
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ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. The effective date of this rider is the Effective Date of the policy, unless otherwise indicated _____.

This rider is added to and made a part of the policy to which it is attached. It is issued in consideration of the statements made in the application and the payment of the premium as shown on the Policy Schedule Page, or as shown by endorsement. It is subject to all the definitions, provisions, terms, conditions, exclusions and limitations of the policy which are not inconsistent with the provisions of this rider.

PART 1: DEFINITIONS

COVERED ACCIDENT: means a sudden, unexpected and unintended event which causes an Injury or Injuries to an Insured Person, occurs while this policy is in force for the Insured Person and is not excluded in this rider or the policy to which this rider is attached.

INJURY means an accidental bodily Injury sustained by an Insured Person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and that occurs while this policy is in force.

BENEFIT AMOUNT means the amount We will pay for an Accidental Death or Dismemberment as shown on the Policy Schedule Page.

PART 2: BENEFITS PROVIDED BY THIS RIDER

TABLE OF BENEFITS

In the Event of Loss of:	**The Benefit Will Be:**
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount

ACCIDENTAL DEATH BENEFIT:
We will pay the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of life due to Injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT:
We will pay a percentage of the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of sight or limb(s) due to injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. The loss of hand or foot means the complete severance at or above the wrist or ankle joint. Loss of eye means total and irrecoverable sight. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

LIMIT ON PAYMENT OF BENEFIT AMOUNT:
The total amount payable under this benefit for all losses resulting from any one Covered Accident shall not exceed the amount payable for loss of life. The amount will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page, for the Insured Person suffering multiple losses. If an Insured Person suffers multiple losses under subsequent Covered Accidents, the amount payable for all subsequent Covered Accidents will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page.

PART 3: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for an Injury resulting, whether directly or indirectly, from any of the following:

(1) Injuries that are intentionally self-inflicted;
(2) suicide or attempted suicide, while sane or insane;
(3) a Covered Accident which occurs outside the United States or its territories;
(4) an act of declared or undeclared war;
(5) an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
(6) committing or attempting to commit a felony or engaging in an illegal occupation or activity;
(7) participation in any sport or sporting activity for wage, compensation or profit;
(8) operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
(9) engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
(10) riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
(11) a work-related condition that is eligible for benefits under Workman's Compensation, Employers' Liability or similar laws even when the Insured Person does not file a claim for benefits. This exclusion will not apply to an Insured Person who is not required to have coverage under any Workman's Compensation, Employers' Liability or similar law and does not have such coverage.

PART 4: TERMINATION PROVISIONS

This rider terminates on the earliest of the following:

(1) the date the policy terminates;
(2) when You fail to pay the required premium within its grace period;
(3) the date specified in Your advance written request to terminate this rider.

If an Insured Person receives 100% of their Benefit Amount from this rider or dies, coverage for that Insured Person under this rider will be terminated. This rider will continue to provide coverage for the other Insured Person(s), if any, until the coverage on the last Insured Person terminates.

PART 5: REINSTATEMENT

If You apply for reinstatement or conversion of the policy, You may apply to reinstate or convert this rider at the same time.

Signed for Loyal American Life Insurance Company at its office in Austin, Texas.

[Brenda Henderson]
SECRETARY

[ ]
PRESIDENT

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Loyal American Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***	***Company Tracking #:*** *LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	08/17/2012
Comments:			
Attachment(s):			
Flesch Score -FDC-FDH-AR.pdf AR Certification Reg19 - Signed.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	09/07/2012
Comments:			
Attachment(s):			
LY-FDCH-APP-GN_10.18.11.pdf LOYAL-FDC-S.App.pdf LY-FDC-APP-GN_10.18.11.pdf LY-FDH-APP-GN_10.18.11.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/17/2012
Comments:			
Attachment(s):			
LY-FDC-OC-GN_10.17.11.pdf LY-FDH-OC-GN_10.17.11.pdf			

Loyal American
Life Insurance Company®
P.O. Box 559004 ◆ Austin, Texas 78755-9004 ◆ 800-633-6752

CERTIFICATION OF FLESCH READING EASE TEST

This is to certify that the forms listed below are in compliance with the readability requirements of the Flesch Reading ease test.

The Flesch test was applied to each form in its entirety, except that of titles, major headings and sub-headings and tables were excluded.

The Flesch reading ease test scores are:

FIRST DIAGNOSIS CANCER/FIRST DIAGNOSIS HEART FORMS

Form Number	Description	Form Type	Flesch Score
LY-FDC-BA-AR	First Diagnosis Cancer Insurance Policy	POL	40
LY-FDC-BA.SCH.PG-AR	First Diagnosis Cancer Schedule Page	SCH	40
LY-FDH-BA-AR	First Diagnosis Heart and Stroke Insurance Policy	POL	40
LY-FDC-BA.SCH.PG-AR	First Diagnosis Heart and Stroke Schedule Page	SCH	40
LY-FDC-RD	First Diagnosis Cancer Rider	POLA	40
LY-FDH-RD	First Diagnosis Heart and Stroke Rider	POLA	40
LY-SD-RD	Specified Disease Rider	POLA	40
LY-ROP-D	Return of Premium Rider	POLA	40
LY-ROP-D85	Return of Premium (85) Rider	POLA	40
LY-ROP-T20	Return of Premium Upon Termination (20 Year) Rider	POLA	40
LY-ROP-T15	Return of Premium Upon Termination (15 Year) Rider	POLA	40
LY-ADD-R3	Accidental Death and Dismemberment Rider	POLA	40

LY-FDC-OC-GN	First Diagnosis Cancer Outline of Coverage	OUT	40
LY-FDH-OC-GN	First Diagnosis Heart and Stroke Outline of Coverage	OUT	40
LY-FDC-APP.V2-GN	First Diagnosis Cancer Application	AEF	40
LY-FDH-APP.V2-GN	First Diagnosis Heart and Stroke Application	AEF	40
LY-FDCH-APP-GN	First Diagnosis Cancer/ First Diagnosis Heart and Stroke Application	AEF	40

LOYAL AMERICAN LIFE INSURANCE COMPANY®

_____

Printed Name: Bradley A. Wolfram
Title: President

Date: May 23, 2012

Arkansas Certification

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

Julie Cook

Julie Cook,MCM
Compliance Filing Specialist

May 23, 2012
Date

Loyal American
Life Insurance Company®

Application for [First Diagnosis Cancer Insurance Policy] [and/or] [First Diagnosis Heart and Stroke Insurance Policy]

[P.O. Box 559015, Austin, TX 78755-9015, 800-633-6752]

Application is for: [☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Requested Effective Date _____ [Existing Policy Number _____] [PV Case #_____]

SECTION A: APPLICANT'S INFORMATION (Please Print)

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ Email _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (If other than Applicant) Payor Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION (Please Print)

SPOUSE TO BE COVERED

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Work Phone ( ) _____ Home Phone ( ) _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

CHILD(REN) TO BE COVERED (Please attach a separate sheet if needed.)

	Name: First, MI, Last	Social Security #	Sex	Age	Date of Birth Month/Day/Year	Full Time Student?
Child # 1						☐ Y ☐ N
Child # 2						☐ Y ☐ N
Child # 3						☐ Y ☐ N
Child # 4						☐ Y ☐ N

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If yes, have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant: _____ Spouse: _____

Applicant Employer/Job: _____ Title/Duties: _____

Spouse Employer/Job: _____ Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) *Complete the Electronic Funds Transfer Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ DIRECT BILL]
[Premium Mode: [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ LIST BILL]
[Pemium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay] [☐ 52 Pay]]

[Group Name: _____] [Group Number: _____]
[Is this a Section 125? ☐ Yes ☐ No]

[☐ CREDIT CARD *Complete the Credit Card Payment Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Cancer (FDC) Policy* Benefit Amount: $ _____ Base Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ First Diagnosis Heart/Stroke (FDH) Policy** Benefit Amount:$ _____ Base Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

*[(*FDC Policy can not be written with FDC Rider; **FDH Policy can not be written with FDH Rider)]*

[Total Base Modal Premium $ _____]

[OPTIONAL RIDERS SELECTION *(for additional premium)*]

[☐ First Diagnosis Cancer (FDC) Rider* Benefit Amount: $ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ First Diagnosis Heart/Stroke (FDH) Rider** Benefit Amount:$ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

*[(*FDC Rider can not be written with FDC Policy; **FDH Rider can not be written with FDH Policy)]*

[☐ Specified Disease Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider [☐ $25,000] [☐ $50,000] [☐ $75,000] [☐ $100,000]
[(if applying, Child(ren) benefit is $[25,000])] Rider Modal Premium $ _____]

[Total Optional Riders Modal Premium $ _____]

[OPTIONAL RETURN OF PREMIUM RIDER[S] SELECTION *(for additional premium)*]

Select One: [☐ Return of Premium)] [☐ Return of Premium Upon Termination (15 Years)]
[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]

[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

Total Base[/Optional Riders/][Optional ROP Rider] Modal Premium $ _____]

[One Time Enrollment Fee $ _____]

[Total Premium with Application $ _____]

Make checks payable to Loyal American Life Insurance Company

SECTION G: NON-MEDICAL QUESTIONS

	YES	NO
1. Does any applicant currently have any Accident, Cancer or Heart insurance coverage in force? If yes, list the name of Company and Policy Number and Coverage Amount.	☐	☐
2. Is the Insurance applied for here intended to replace any existing or pending Accident, Cancer or Heart insurance? If yes, complete the provided replacement form, and list the name of Company and Policy Number	☐	☐
3. During the past five (5) years, has any applicant had an Accident, Cancer or Heart insurance application postponed, rated up or declined, or had insurance renewal or reinstatement refused?	☐	☐
4. Is any applicant eligible for Medicare?	☐	☐
5. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)?	☐	☐

SECTION H: TOBACCO USE

	Applicant	Spouse
Have you used tobacco within the last five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION I: MEDICAL QUESTIONS

(If the answer to any question in this section is YES the applicant is not eligible for coverage.)

ALL POLICIES AND RIDERS (*Please Answer Questions #1 - #2*)

	YES	NO
1. Have you or any applicant ever been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS),AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV) Infection?	☐	☐
2. Within the past five (5) years, have you or any applicant received, been advised to receive, or sought any medical advice, examination, or treatment for drug or alcohol abuse, addiction, or dependency?	☐	☐

FIRST DIAGNOSIS CANCER POLICY/RIDER *(Please Answer Questions #3 - #5)*

	YES	NO
3. Have you or any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
4. Have you or any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
5. Have you or any applicant ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

FIRST DIAGNOSIS HEART/STROKE POLICY/RIDER [AND SPECIFIED DISEASE RIDER]
(Please Answer Questions #6 - #7)

	YES	NO
6. Have you or any applicant ever:		
a. Been diagnosed with or received medical advice or treatment for Heart Attack, Angina, Arrhythmia, Congenital Heart Defect,Cardiomyopathy, Congestive Heart Failure, Coronary Artery Disease (CAD), Carotid Artery Disease,Peripheral Vascular Disease, Cardiac or Vascular Angioplasty, Stroke, Transient Ischemic Attack (TIA), Pulmonary Hypertension, Blood Clots, or Disease or Disorder of the Heart or Circulatory System not listed?	☐	☐
b. Had or been advised to have any form of Heart or Heart Valve Surgery, Coronary Artery Surgery, Bypass Surgery, Endarterectomy, Arteriogram, Cardiac or Vascular Angioplasty, Stent Placement, or Implantation of Cardiac Pacemaker or Defibrillator?	☐	☐
c. Been diagnosed with or received medical advice or treatment for Insulin Dependent Diabetes (excluding Gestational Diabetes), Diabetes with Neuropathy or Retinopathy or Connective Tissue Disorders such as Cystic Fibrosis?	☐	☐
d. Been prescribed three (3) or more medications to be taken concurrently for High Blood Pressure?	☐	☐

FIRST DIAGNOSIS HEART/STROKE POLICY/RIDER [AND SPECIFIED DISEASE RIDER] *(Continued)*

	YES	NO
7. Within the last six (6) months have you or any applicant:		
a. Been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	☐	☐
b. Had three (3) or more blood pressure readings over 140/90?	☐	☐
c. Been advised that your blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure?	☐	☐

[SPECIFIED DISEASE RIDER *(Please Answer Questions #8 - #9)*

	YES	NO
8. Have you or any applicant ever been diagnosed with or received medical advice or treatment for any of the following conditions?		
a. Kidney Disease requiring dialysis, Renal Insufficiency, Renal Failure, or Polycystic Kidney Disease?	☐	☐
b. Liver Disease including Cirrhosis or Hepatitis (other than A)?	☐	☐
c. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Obstructive Lung Disease (COLD) excluding Asthma, Pulmonary Fibrosis or any Lung or Respiratory Disorder requiring the use of oxygen?	☐	☐
d. Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), or Paralysis?	☐	☐
9. Have you or any applicant ever had an Organ transplant, bone marrow transplant or been advised of a need for a transplant?	☐	☐

[ACCIDENTAL DEATH AND DISMEMBERMENT RIDER *(Please Answer Questions #[10] & #[11])*

	YES	NO
10. Has any applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last five (5) years?	☐	☐
11. Has any applicant participated in or intend to participate in, and/or is currently participating in piloting, parachuting, sky diving, hang-gliding, motor racing, sporting activity(ies) for wage, compensation or profit, or any other hazardous activity(ies)	☐	☐

SECTION J: MEDICATION(S) *(REQUIRED FOR ALL POLICIES AND RIDERS)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Dates Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); (3) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (4) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.
THIS POLICY PROVIDES LIMITED BENEFITS, REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I or any applicant now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ **Date:** _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the applicant. The applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant 's Statements and Agreements

Was the application completed by you in the applicant's physical presence?..... ☐ Yes ☐ No

Was the application completed by you over the phone?..... ☐ Yes ☐ No

I further certify that on _____ I delivered the documents to the applicant ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax
(Date) (check all that apply, must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage

Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage

Loyal American Life Insurance Company®

PV Case # _____

Cancer Insurance Addition

(Not valid for tobacco users or if you are applying for a Medicare Supplement policy during an open enrollment period or on a Guaranteed Issue basis.)

[P.O. Box 559015, Austin, TX 78755-9015]

Upon issue of your Medicare Supplement policy, you may qualify for a [$5,000] First Diagnosis Cancer Insurance Policy if you can answer "No" to three additional questions. You may add this important coverage by simply completing and returning this form to the company with your Medicare Supplement application.

HEALTH QUESTIONS *(If the answer to any question in this section is YES, the applicant is not eligible for coverage.)*

		Yes	No
1.	Have you ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
2.	Have you ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
3.	Have you ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

Monthly bank draft rates for [$5,000] of supplemental First Diagnosis Cancer protection:

Issue Ages	Female Rates	Male Rates
[65-69]	[$11.60]	[$16.19]
[70-74]	[$13.52]	[$19.81]
[75-80]	[$14.75]	[$21.72]

The billing frequency for your First Diagnosis Cancer Policy will match your Medicare Supplement Policy. The above rates shown are monthly bank draft rates. Consult our rate chart for other billing frequencies.

Med Supp billing frequency: ☐Monthly ☐Quarterly ☐Semi-Annual ☐Annual

First Diagnosis Cancer Policy Modal Premium $_____

Is the Insurance applied for here intended to replace any existing or pending Cancer insurance? ☐Yes ☐No

If yes, list the Company and Policy Number _____ and complete the applicable replacement form.

I acknowledge and agree that Loyal's issuance of this cancer insurance policy is reliant upon the information contained above and in the application I completed for my Loyal American Medicare Supplement policy which shall become a part of the cancer insurance policy I am purchasing, and any misstatement of material facts contained in either application may result in the rescission of this cancer insurance policy. I understand and agree that (1) there will be no coverage until my application is approved by the Company; (2) the initial premium has been paid; (3) this form and Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance, if applicable, are received at the Home Office; and (4) the policy has been issued by the Company. I understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); and (3) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable the required Guide to Health Insurance for People with Medicare. THIS POLICY IS A FIRST DIAGNOSIS CANCER ONLY POLICY. I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I now have, or have had in the past twelve (12) months.

By signing below, I hereby request that Loyal issue a First Diagnosis Cancer Insurance Policy form number series LY-FDC-BA. I understand my bank account will be drafted for the additional premium and my effective date will be the same as my Medicare Supplement policy.

Applicant's Printed Name	Signature Of Applicant	Date
Agent's Printed Name	Signature Of Agent	Writing Number

Loyal American Life Insurance Company®

Application for First Diagnosis Cancer Insurance Policy

[P.O. Box 559015, Austin, TX 78755-9015, 800-633-6752]

Application is for: [☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Requested Effective Date _____ [Existing Policy Number _____] [PV Case #_____]

SECTION A: APPLICANT'S INFORMATION (Please Print)

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ Email _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (If other than Applicant) Payor Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION (Please Print)

SPOUSE TO BE COVERED

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Work Phone ( ) _____ Home Phone ( ) _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

CHILD(REN) TO BE COVERED (Please attach a separate sheet if needed.)

	Name: First, MI, Last	Social Security #	Sex	Age	Date of Birth Month/Day/Year	Full Time Student?
Child # 1						☐ Y ☐ N
Child # 2						☐ Y ☐ N
Child # 3						☐ Y ☐ N
Child # 4						☐ Y ☐ N

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If yes, have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant: _____ Spouse: _____

Applicant Employer/Job: _____ Title/Duties: _____

Spouse Employer/Job: _____ Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) *Complete the Electronic Funds Transfer Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ DIRECT BILL]
[Premium Mode: [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ LIST BILL]
[Pemium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay] [☐ 52 Pay]]

[Group Name: _____] [Group Number: _____]
[Is this a Section 125? ☐ Yes ☐ No]

[☐ CREDIT CARD *Complete the Credit Card Payment Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Cancer Policy Benefit Amount: $ _____ **Total Base Modal Premium $** _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount)]

[OPTIONAL RIDERS SELECTION *(for additional premium)*]

[☐ First Diagnosis Heart/Stroke Rider Benefit Amount:$ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Specified Disease Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider [☐ $25,000] [☐ $50,000] [☐ $75,000] [☐ $100,000]
[(if applying, Child(ren) benefit is $[25,000])] Rider Modal Premium $ _____]

[Total Optional Riders Modal Premium $ _____]

[OPTIONAL RETURN OF PREMIUM RIDER[S] SELECTION *(for additional premium)*]

Select One: [☐ Return of Premium)] [☐ Return of Premium Upon Termination (15 Years)]
[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]

[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

Total Base[/Optional Riders][/Optional ROP Rider] Modal Premium $ _____]

[One Time Enrollment Fee $ _____]

Total Premium with Application $ _____

Make checks payable to Loyal American Life Insurance Company

SECTION G: NON-MEDICAL QUESTIONS

	YES	NO
1. Does any applicant currently have any Accident, Cancer or Heart insurance coverage in force? If yes, list the name of Company and Policy Number and Coverage Amount.	☐	☐
2. Is the Insurance applied for here intended to replace any existing or pending Accident, Cancer or Heart insurance? If yes, complete the provided replacement form, and list the name of Company and Policy Number.	☐	☐

SECTION G: NON-MEDICAL QUESTIONS (Continued)

3. During the past five (5) years, has any applicant had an Accident, Cancer or Heart insurance application .....postponed, rated up or declined, or had insurance renewal or reinstatement refused? ☐ ☐
4. Is any applicant eligible for Medicare? ☐ ☐
5. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)? ☐ ☐

SECTION H: TOBACCO USE

	Applicant	Spouse
Have you used tobacco within the last five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION I: MEDICAL QUESTIONS

(If the answer to any question in this section is YES the applicant is not eligible for coverage.)

FIRST DIAGNOSIS CANCER POLICY (*Please Answer Questions #1 - #5*) **YES NO**

1. Have you or any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ? ☐ ☐
2. Have you or any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal? ☐ ☐
3. Have you or any applicant ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher? ☐ ☐
4. Have you or any applicant ever been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS),AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV) Infection? ☐ ☐
5. Within the past five (5) years, have you or any applicant received, been advised to receive, or sought any medical advice, examination, or treatment for drug or alcohol abuse, addiction, or dependency? ☐ ☐

[FIRST DIAGNOSIS HEART/STROKE RIDER] [AND] [SPECIFIED DISEASE RIDER]
(Please Answer Questions #6 & #7) **YES NO**

Have you or any applicant ever:

6. a. Been diagnosed with or received medical advice or treatment for Heart Attack, Angina, Arrhythmia, Congenital Heart Defect,Cardiomyopathy, Congestive Heart Failure, Coronary Artery Disease (CAD), Carotid Artery Disease,Peripheral Vascular Disease, Cardiac or Vascular Angioplasty, Stroke, Transient Ischemic Attack (TIA), Pulmonary Hypertension, Blood Clots, or Disease or Disorder of the Heart or Circulatory System not listed? ☐ ☐
   b. Had or been advised to have any form of Heart or Heart Valve Surgery, Coronary Artery Surgery, Bypass Surgery, Endarterectomy, Arteriogram, Cardiac or Vascular Angioplasty, Stent Placement, or Implantation of Cardiac Pacemaker or Defibrillator? ☐ ☐
   c. Been diagnosed with or received medical advice or treatment for Insulin Dependent Diabetes (excluding Gestational Diabetes), Diabetes with Neuropathy or Retinopathy or Connective Tissue Disorders such as Cystic Fibrosis? ☐ ☐
   d. Been prescribed three (3) or more medications to be taken concurrently for High Blood Pressure? ☐ ☐
7. Within the last six (6) months have you or any applicant:
   a. Been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ☐ ☐
   b. Had three (3) or more blood pressure readings over 140/90? ☐ ☐
   c. Been advised that your blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure? ☐ ☐

[SPECIFIED DISEASE RIDER *(Please Answer Questions #8 & #9)* **YES NO**

8. Have you or any applicant ever been diagnosed with or received medical advice or treatment for any of the following conditions?
   a. Kidney Disease requiring dialysis, Renal Insufficiency, Renal Failure, or Polycystic Kidney Disease? ☐ ☐
   b. Liver Disease including Cirrhosis or Hepatitis (other than A)? ☐ ☐
   c. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Obstructive Lung Disease (COLD) excluding Asthma, Pulmonary Fibrosis or any Lung or Respiratory Disorder requiring the use of oxygen? ☐ ☐
   d. Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), or Paralysis? ☐ ☐
9. Have you or any applicant ever had an Organ transplant, bone marrow transplant or been advised of a need for a transplant? ☐ ☐

[ACCIDENTAL DEATH AND DISMEMBERMENT RIDER *(Please Answer Questions #[10] & #[11])* **YES NO**

10. Has any applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last five (5) years? ☐ ☐
11. Has any applicant participated in or intend to participate in, and/or is currently participating in piloting, parachuting, sky diving, hang-gliding, motor racing, sporting activity(ies) for wage, compensation or profit, or any other hazardous activity(ies)? ☐ ☐

SECTION J: MEDICATION(S) *(REQUIRED FOR POLICY AND RIDERS)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Dates Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); (3) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (4) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.

THIS POLICY PROVIDES LIMITED BENEFITS, REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I or any applicant now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ **Date:** _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the applicant. The applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant 's Statements and Agreements

Was the application completed by you in the applicant's physical presence? ☐ Yes ☐ No

Was the application completed by you over the phone? ☐ Yes ☐ No

I further certify that on _____ (Date) I delivered the documents to the applicant ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax (check all that apply, must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage

Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage

Loyal American Life Insurance Company®

Application for First Diagnosis Heart and Stroke Insurance Policy

[P.O. Box 559015, Austin, TX 78755-9015, 800-633-6752]

Application is for: [☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Requested Effective Date _____ [Existing Policy Number _____] [PV Case #_____]

SECTION A: APPLICANT'S INFORMATION (Please Print)

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ Email _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (If other than Applicant) Payor Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION (Please Print)

SPOUSE TO BE COVERED

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Work Phone ( ) _____ Home Phone ( ) _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

CHILD(REN) TO BE COVERED (Please attach a separate sheet if needed.)

	Name: First, MI, Last	Social Security #	Sex	Age	Date of Birth Month/Day/Year	Full Time Student?
Child # 1						☐ Y ☐ N
Child # 2						☐ Y ☐ N
Child # 3						☐ Y ☐ N
Child # 4						☐ Y ☐ N

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If yes, have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant: _____ Spouse: _____

Applicant Employer/Job: _____ Title/Duties: _____

Spouse Employer/Job: _____ Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) *Complete the Electronic Funds Transfer Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ DIRECT BILL]
[Premium Mode: [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ LIST BILL]
[Pemium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay] [☐ 52 Pay]]

[Group Name: _____] [Group Number: _____]
[Is this a Section 125? ☐ Yes ☐ No]

[☐ CREDIT CARD *Complete the Credit Card Payment Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Heart and Stroke Policy Benefit Amount: $ _____ **Base Modal Premium $** _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[OPTIONAL RIDER[S] SELECTION *(for additional premium)*]

[☐ First Diagnosis Cancer Rider Benefit Amount: $ _____ .. Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Specified Disease Rider Benefit Amount: $ _____ . Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider [☐ $25,000] [☐ $50,000] [☐ $75,000] [☐ $100,000]
[(if applying, Child(ren) benefit is $[25,000])] ... Rider Modal Premium $ _____]

.....**[Total Optional Rider[s] Modal Premium $** _____]

[OPTIONAL RETURN OF PREMIUM RIDER[S] SELECTION *(for additional premium)*]

Select One: [☐ Return of Premium)] [☐ Return of Premium Upon Termination (15 Years)]
[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]
[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

Total Base[/Optional Riders][/Optional ROP Rider] Modal Premium $ _____]

[One Time Enrollment Fee $ _____]

[Total Premium with Application $ _____]

Make checks payable to Loyal American Life Insurance Company

SECTION G: NON-MEDICAL QUESTIONS

	YES	NO
1. Does any applicant currently have any Accident, Cancer or Heart insurance coverage in force? If yes, list the name of Company and Policy Number and Coverage Amount.	☐	☐
2. Is the Insurance applied for here intended to replace any existing or pending Accident, Cancer or Heart insurance? If yes, complete the provided replacement form, and list the name of Company and Policy Number	☐	☐
3. During the past five (5) years, has any applicant had an Accident, Cancer or Heart insurance application postponed, rated up or declined, or had insurance renewal or reinstatement refused?	☐	☐
4. Is any applicant eligible for Medicare?	☐	☐
5. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)?	☐	☐

SECTION H: TOBACCO USE

	Applicant	Spouse
Have you used tobacco within the last five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION I: MEDICAL QUESTIONS

(If the answer to any question in this section is YES the applicant is not eligible for coverage.)

FIRST DIAGNOSIS HEART POLICY [AND SPECIFIED DISEASE RIDER]

(***Please Answer Questions #1 - #4***)	YES	NO
1. Have you or any applicant ever:		
a. Been diagnosed with or received medical advice or treatment for Heart Attack, Angina, Arrhythmia, Congenital Heart Defect,Cardiomyopathy, Congestive Heart Failure, Coronary Artery Disease (CAD), Carotid Artery Disease,Peripheral Vascular Disease, Cardiac or Vascular Angioplasty, Stroke, Transient Ischemic Attack (TIA), Pulmonary Hypertension, Blood Clots, or Disease or Disorder of the Heart or Circulatory System not listed?	☐	☐
b. Had or been advised to have any form of Heart or Heart Valve Surgery, Coronary Artery Surgery, Bypass Surgery, Endarterectomy, Arteriogram, Cardiac or Vascular Angioplasty, Stent Placement, or Implantation of Cardiac Pacemaker or Defibrillator?	☐	☐
c. Been diagnosed with or received medical advice or treatment for Insulin Dependent Diabetes (excluding Gestational Diabetes), Diabetes with Neuropathy or Retinopathy or Connective Tissue Disorders such as Cystic Fibrosis? ☐ ☐		
d. Been prescribed three (3) or more medications to be taken concurrently for High Blood Pressure?	☐	☐
2. Within the last six (6) months have you or any applicant:		
a. Been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	☐	☐
b. Had three (3) or more blood pressure readings over 140/90? ☐ ☐		
c. Been advised that your blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure?	☐	☐
3. Have you or any applicant ever been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS),AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV) Infection? ☐ ☐		
4. Within the past five (5) years, have you or any applicant received, been advised to receive, or sought any medical advice, examination, or treatment for drug or alcohol abuse, addiction, or dependency?	☐	☐

[FIRST DIAGNOSIS CANCER RIDER *(Please Answer Questions #5 - #7)*

	YES	NO
5. Have you or any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
6. Have you or any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
7. Have you or any applicant ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

[SPECIFIED DISEASE RIDER *(Please Answer Questions #8 & #9)*

	YES	NO
8. Have you or any applicant ever been diagnosed with or received medical advice or treatment for any of the following conditions?		
a. Kidney Disease requiring dialysis, Renal Insufficiency, Renal Failure, or Polycystic Kidney Disease?	☐	☐
b. Liver Disease including Cirrhosis or Hepatitis (other than A)?	☐	☐
c. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Obstructive Lung Disease (COLD) excluding Asthma, Pulmonary Fibrosis or any Lung or Respiratory Disorder requiring the use of oxygen?	☐	☐
d. Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), or Paralysis?	☐	☐
9. Have you or any applicant ever had an Organ transplant, bone marrow transplant or been advised of a need for a transplant?	☐	☐

[ACCIDENTAL DEATH AND DISMEMBERMENT RIDER *(Please Answer Questions #[10] & #[11])*

	YES	NO
10. Has any applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last five (5) years?	☐	☐
11. Has any applicant participated in or intend to participate in, and/or is currently participating in piloting, parachuting, sky diving, hang-gliding, motor racing, sporting activity(ies) for wage, compensation or profit, or any other hazardous activity(ies)?	☐	☐

12. SECTION J: MEDICATION(S) *(REQUIRED FOR POLICY AND RIDERS)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Dates Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); (3) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (4) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.

THIS POLICY PROVIDES LIMITED BENEFITS, REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ **Date:** _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the applicant. The applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant 's Statements and Agreements

Was the application completed by you in the applicant's physical presence?..... ☐ Yes ☐ No

Was the application completed by you over the phone?..... ☐ Yes ☐ No

I further certify that on _____ I delivered the documents to the applicant ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax
(Date) (check all that apply, must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage

Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage

Loyal American
Life Insurance Company®
[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

OUTLINE OF COVERAGE FOR FIRST DIAGNOSIS CANCER INSURANCE POLICY FORM SERIES LY-FDC-BA

SPECIFIED DISEASE COVERAGE
THIS POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

1. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

2. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.

3. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

4. ***BENEFITS PROVIDED BY THE POLICY***

FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician, We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

1. 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
2. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis shall occur while the Insured Person is covered by this policy; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the policy. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this policy's Effective Date, coverage for the Insured Person under the this policy will end.

5. EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy:

1. for any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
2. loss that begins prior to the Effective Date of coverage;
3. Diagnosis and treatment received outside the United States or its territories; or
4. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

6. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

7. OPTIONAL BENEFIT RIDERS (**Additional Premiums Required)** - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

[☐ **FIRST DIAGNOSIS HEART AND STROKE BENEFIT RIDER (Form # LY-FDH-RD)**

We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

1. The First Ever Diagnosis or Procedure must be made and performed within the United States; and
2. the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this rider; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

* We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this rider. Payment of benefits is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

1. any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
2. intentionally self-inflicted injury or Sickness;
3. suicide or attempted suicide, while sane or insane;
4. loss that begins prior to the Effective Date of coverage;
5. Diagnosis and treatment received outside the United States or its territories;

6. any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
7. any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this rider.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.]

[☐ **SPECIFIED DISEASE RIDER (Form # LY-SD-RD)**

We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this rider.

Specified Diseases
Amyotrophic Lateral Sclerosis (ALS)
Coma
End Stage Renal Failure
Major Organ Transplant
Multiple Sclerosis (MS)
Paralysis
Severe Burns

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this rider for the same Insured Person.

If the Date of Diagnosis or Procedure of two (2) or more Specified Diseases is the same day, We will pay only one (1) Specified Disease benefit.

No benefits are payable for conditions other than the Specified Diseases defined in this rider. Payment of the Specified Disease benefit is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS
This Rider does not cover any disease, Sickness, incapacity or procedure other than the Specified Diseases defined above, even though another disease or incapacity may have been complicated, aggravated or directly affected by the Specified Disease or its treatment.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for any Sickness or Injury resulting, whether directly or indirectly, from any of the following:

1. intentionally self-inflicted Sickness or Injury;
2. suicide or attempted suicide, while sane or insane;
3. loss that begins prior to the Effective Date of coverage;
4. care and treatment received outside the United States or its territories;
5. an act of declared or undeclared war;
6. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
7. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
8. participation in any sport or sporting activity for wage, compensation or profit;
9. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
10. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
11. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
12. any illness specifically excluded from the definition of any Specified Disease.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.]

[☐ **ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER (Form # LY-ADD-RD3)**

TABLE OF BENEFITS

In the Event of Loss of:	**The Benefit Will Be:**
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount

ACCIDENTAL DEATH BENEFIT:
We will pay the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of life due to Injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT:
We will pay a percentage of the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of sight or limb(s) due to injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. The loss of hand or foot means the complete severance at or above the wrist or ankle joint. Loss of eye means total and irrecoverable sight. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

LIMIT ON PAYMENT OF BENEFIT AMOUNT:
The total amount payable under this benefit for all losses resulting from any one Covered Accident shall not exceed the amount payable for loss of life. The amount will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page, for the Insured Person suffering multiple losses. If an Insured Person suffers multiple losses under subsequent Covered Accidents, the amount payable for all subsequent Covered Accidents will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for an Injury resulting, whether directly or indirectly, from any of the following:

1. Injuries that are intentionally self-inflicted;
2. suicide or attempted suicide, while sane or insane;
3. a Covered Accident which occurs outside the United States or its territories;
4. an act of declared or undeclared war;
5. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
6. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
7. participation in any sport or sporting activity for wage, compensation or profit;
8. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
9. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
10. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
11. a work-related condition that is eligible for benefits under Workman's Compensation, Employers' Liability or similar laws even when the Insured Person does not file a claim for benefits. This exclusion will not apply to an Insured Person who is not required to have coverage under any Workman's Compensation, Employers' Liability or similar law and does not have such coverage.]

[☐ **RETURN OF PREMIUM RIDER (Form # LY-ROP-D)**
In the event You die while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM (85) RIDER (Form # LY-ROP-D85)**

In the event You die prior to Your eighty-sixth (86th) birthday while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM UPON TERMINATION (15 YEARS) RIDER (Form #LY-ROP-T15)**

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for fifteen (15) consecutive years beginning with the Rider Effective Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM UPON TERMINATION (20 YEARS) RIDER (Form # LY-ROP-T20)**

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for twenty (20) consecutive years beginning with the Rider Effective

Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

***8. <u>YOUR TOTAL ANNUAL PREMIUM</u>* <u>(At time of application)</u>:**

	Tobacco	Gender	Age	FDC Policy	[FDH Rider	[SD Rider	[AD&D Rider	[ROP Rider
SELF	☐Y / ☐N	☐M / ☐F						
SPOUSE	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
TOTAL ANNUAL PREMIUM				$	$]	$]	$]	$]

(Please attach a separate sheet if needed)

[There will be a one-time enrollment fee of [$0.00 to $40.00] added to the first premium.]

Loyal American
Life Insurance Company®

[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

OUTLINE OF COVERAGE FOR FIRST DIAGNOSIS HEART INSURANCE POLICY FORM SERIES LY-FDH-BA

SPECIFIED DISEASE COVERAGE
THIS POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

1. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

2. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.

3. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

4. ***BENEFITS PROVIDED BY THE POLICY***

We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

1. The First Ever Diagnosis or Procedure must be made and performed within the United States; and
2. the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this policy; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

* We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this policy. Payment of benefits is subject to all terms and conditions of this policy.

5. EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy for:

1. any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
2. intentionally self-inflicted injury or Sickness;
3. suicide or attempted suicide, while sane or insane;
4. loss that begins prior to the Effective Date of coverage;
5. Diagnosis and treatment received outside the United States or its territories;

6. any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
7. any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this policy.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

6. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

7. OPTIONAL BENEFIT RIDERS (**Additional Premiums Required)** - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

[☐ **FIRST DIAGNOSIS CANCER BENEFIT RIDER (Form # LY-FDC-RD)**

Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured Person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

1. 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
2. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	**% of Recurrence Benefit Amount Payable for Cancer**	**% of Recurrence Benefit Amount Payable for Carcinoma in Situ***	**Maximum Percentage of the Recurrence Benefit Amount**
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis shall occur while the Insured Person is covered by this rider; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the rider. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this rider's Effective Date, coverage for the Insured Person under the this rider will end.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

1. any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
2. loss that begins prior to the Effective Date of coverage;
3. Diagnosis and treatment received outside the United States or its territories; or
4. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.]

[☐ **SPECIFIED DISEASE RIDER (Form # LY-SD-RD)**

We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this rider.

Specified Diseases
Amyotrophic Lateral Sclerosis (ALS)
Coma
End Stage Renal Failure
Major Organ Transplant
Multiple Sclerosis (MS)
Paralysis
Severe Burns

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this rider for the same Insured Person.

If the Date of Diagnosis or Procedure of two (2) or more Specified Diseases is the same day, We will pay only one (1) Specified Disease benefit.

No benefits are payable for conditions other than the Specified Diseases defined in this rider. Payment of the Specified Disease benefit is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS

This Rider does not cover any disease, Sickness, incapacity or procedure other than the Specified Diseases defined above, even though another disease or incapacity may have been complicated, aggravated or directly affected by the Specified Disease or its treatment.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for any Sickness or Injury resulting, whether directly or indirectly, from any of the following:

1. intentionally self-inflicted Sickness or Injury;
2. suicide or attempted suicide, while sane or insane;
3. loss that begins prior to the Effective Date of coverage;
4. care and treatment received outside the United States or its territories;
5. an act of declared or undeclared war;
6. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
7. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
8. participation in any sport or sporting activity for wage, compensation or profit;
9. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
10. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
11. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
12. any illness specifically excluded from the definition of any Specified Disease.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.]

[☐ ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER (Form # LY-ADD-RD3)

TABLE OF BENEFITS

In the Event of Loss of:	The Benefit Will Be:
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount

ACCIDENTAL DEATH BENEFIT:
We will pay the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of life due to Injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT:
We will pay a percentage of the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of sight or limb(s) due to injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. The loss of hand or foot means the complete severance at or above the wrist or ankle joint. Loss of eye means total and irrecoverable sight. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

LIMIT ON PAYMENT OF BENEFIT AMOUNT:
The total amount payable under this benefit for all losses resulting from any one Covered Accident shall not exceed the amount payable for loss of life. The amount will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page, for the Insured Person suffering multiple losses. If an Insured Person suffers multiple losses under subsequent Covered Accidents, the amount payable for all subsequent Covered Accidents will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for an Injury resulting, whether directly or indirectly, from any of the following:

1. Injuries that are intentionally self-inflicted;
2. suicide or attempted suicide, while sane or insane;
3. a Covered Accident which occurs outside the United States or its territories;
4. an act of declared or undeclared war;
5. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
6. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
7. participation in any sport or sporting activity for wage, compensation or profit;
8. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
9. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
10. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
11. a work-related condition that is eligible for benefits under Workman's Compensation, Employers' Liability or similar laws even when the Insured Person does not file a claim for benefits. This exclusion will not apply to an Insured Person who is not required to have coverage under any Workman's Compensation, Employers' Liability or similar law and does not have such coverage.]

[☐ **RETURN OF PREMIUM RIDER (Form # LY-ROP-D)**

In the event You die while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM (85) RIDER (Form # LY-ROP-D85)**

In the event You die prior to Your eighty-sixth (86th) birthday while this rider is in force, a return of premium benefit may be payable to your named Beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the return of premium benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM UPON TERMINATION (15 YEARS) RIDER (Form #LY-ROP-T15)**

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for fifteen (15) consecutive years beginning with the Rider Effective Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

[☐ **RETURN OF PREMIUM UPON TERMINATION (20 YEARS) RIDER (Form # LY-ROP-T20)**

This rider will pay You a return of premium benefit when coverage terminates under the base policy for the original Named Insured, after the policy, any other attached riders and this rider have remained in force for twenty (20) consecutive years beginning with the Rider Effective Date. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The return of premium benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

1. Pay the claim, if it is payable upon the terms of the policy or rider, and then reduce the return of premium benefit by the sum of all Claims Paid; or
2. Pay the return of premium benefit, and then reduce the claim by the amount of the return of premium benefit; or
3. Pay the return of premium benefit if the claim is not payable upon the terms of the Policy or Rider.]

***8. YOUR TOTAL ANNUAL PREMIUM* (At time of application):**

	Tobacco	Gender	Age	FDH Policy	[FDC Rider	[SD Rider	[]AD&D Rider	[ROP Rider
SELF	☐Y / ☐N	☐M / ☐F						
SPOUSE	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
CHILD	☐Y / ☐N	☐M / ☐F						
TOTAL ANNUAL PREMIUM				$	$]	$]	$]	$]

(Please attach a separate sheet if needed.)

[There will be a one-time enrollment fee of [$0.00 to $40.00] added to the first premium.]

SERFF Tracking #:	*UTAC-127366519*	***State Tracking #:***		***Company Tracking #:***	*LOYAL FDC/FDH*

State:	*Arkansas*	***Filing Company:***	*Loyal American Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Loyal FDC/FDH*		
Project Name/Number:	*Loyal FDC/FDH/Loyal FDC/FDH*		

Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/30/2012	Form	First Diagnosis Cancer Insurance Policy	08/17/2012	LY-FDC-BA-AR AS FILED.pdf (Superceded)
04/30/2012	Form	First Diagnosis Heart and Stroke Insurance Policy	08/17/2012	LY-FDH-BA-AR AS FILED.pdf (Superceded)
08/12/2011	Supporting Document	Application	09/07/2012	LY-FDCH-APP-GN_10.18.11.pdf LY-FDC-APP.V2-GN.pdf (Superceded) LY-FDH-APP.V2-GN.pdf (Superceded) LOYAL-FDC-S.App.pdf

Loyal American
Life Insurance Company®

[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS CANCER INSURANCE POLICY

Here is Your new First Diagnosis Cancer Insurance Policy. The language used is easy to understand. Loyal American Life Insurance Company® will be referred to in this policy as "We", "Our", and "Us". "You" or "Your" means the Named Insured.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

RIGHT TO ADJUST FUTURE PREMIUMS. After this policy has been in force for twelve (12) months, We may change the premium rates only if We change them for all policies like Yours in Your state on a premium class basis. A premium class basis is determined by such factors as benefits, age, gender, geographic location, tobacco use and the year the policy is issued. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. If We change the premium rates for all policies of this form issued by Us and in force in Your state, We will inform You in writing at least thirty (30) days before the change occurs at the address shown in Our records.

PRE-EXISTING CONDITION(S). The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s).

IMPORTANT NOTICE! PLEASE READ. Please read the copy of the application attached to this policy. The best time to clear up any questions is now, before a claim arises. Omissions or misstatements in the application could cause an otherwise valid claim to be denied or coverage to be rescinded. Carefully check the application and write to Loyal American Life Insurance Company at [P.O. Box 559004, Austin, Texas 78755-9004] within ten (10) days if any information shown on it is not correct and complete or if any medical history has been left out. The application is a part of this policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

YOU HAVE THE RIGHT TO EXAMINE THIS POLICY FOR THIRTY (30) DAYS. Please read Your policy carefully. If You are not satisfied with Your policy for any reason, You may return the policy to Us. It must be returned within thirty (30) days from receipt of this policy. If returned, the policy will be void from its beginning as though the policy was never issued. Any premium paid on this policy will be refunded.

NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY. THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.
REDUCED BENEFITS WILL BE PROVIDED DURING THE FIRST THIRTY (30) DAYS IMMEDIATELY FOLLOWING THE EFFECTIVE DATE OF THIS POLICY FOR ANY CLAIMS RESULTING FROM CANCER OR CARCINOMA IN SITU.

Brenda Hardison

Secretary President

TABLE OF CONTENTS

PART 1: DEFINITIONS

When We use the following words, this is what We mean:

ADVICE OR TREATMENT means care or services provided by a Physician or other member of the medical profession, acting within the scope of their license, including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition, "Advice or Treatment" does not include Maintenance Drug Therapy or routine follow-up visits to verify if Cancer or Carcinoma in Situ has returned.

BENEFICIARY means the person(s) You named in the application, or by later designation, to receive any death benefit or accrued benefits unpaid at Your death.

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

CANCER means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Blood cancers such as Leukemia, Myelodysplastic Syndrome (MDS) and lymphoma are included. Cancer must be Diagnosed pursuant to a Pathological or Clinical Diagnosis.

While not an exhaustive list, the following premalignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this policy:
(1) pre-malignant lesions (such as intraepithelial neoplasia);
(2) benign tumors or polyps;
(3) early prostate cancer Diagnosed as T1N0M0 or equivalent staging;
(4) Carcinoma in Situ; or
(5) any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

CARCINOMA IN SITU means a Diagnosis of Cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ must be Diagnosed pursuant to a Pathological or Clinical Diagnosis. Carcinoma in Situ includes, but is not limited to:
(1) early prostate cancer Diagnosed as T1N0M0 or equivalent staging; and
(2) melanoma not invading the dermis.

Carcinoma in Situ does not include:
(1) other skin malignancies;
(2) pre-malignant lesions (such as intraepithelial neoplasia); or
(3) benign tumors or polyps.

CHILD(REN) means Your natural child, stepchild, legally adopted child, , a foster child, or court appointed guardianship/order/administrative order for a child including grandchild, who is:
(1) insurable and named on the application;
(2) unmarried;
(3) chiefly dependent on You or Your Spouse for support; and
(4) has not attained the limiting age of nineteen (19) or twenty-six (26) if enrolled as a full-time student in an accredited school or college.

Children may also include a child placed with You for adoption. Such coverage will begin on the date of the filing of a petition for adoption if the coverage is applied for within 60 days after the filing of the petition of adoption. In the case of a newborn, the coverage shall be from the moment of birth if the petition and application for coverage is within 60 days after birth.

Child(ren) also includes dependent child(ren), regardless of age, who:
(1) are mentally or physically handicapped;
(2) became or become handicapped prior to the limiting Age; and
(3) cannot support themselves because of their handicap.

CLINICAL DIAGNOSIS means the Diagnosis of Cancer or Carcinoma in Situ based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer or Carcinoma in Situ only if the following conditions are met:
(1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
(2) there is medical evidence to support the Diagnosis; and
(3) a Physician is treating the Insured Person for Cancer and/or Carcinoma in Situ.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this policy, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records. This includes recurrence of a previously Diagnosed Cancer provided the Insured Person has not received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

DEPENDENTS means Your Spouse and Child(ren) as defined under this section.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of Cancer or Carcinoma in Situ through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this policy.

FIRST EVER DIAGNOSIS means the Diagnosis is the first time ever in the Insured Person's lifetime they have been Diagnosed with Cancer or Carcinoma in Situ.

IMMEDIATE FAMILY means anyone related to an Insured Person in the following manner: the Spouse, father (including stepfather), mother (including stepmother), sons (including stepsons), daughters (including stepdaughter), brothers or sisters (including stepbrothers or stepsisters), grandchildren, or father-in-law or mother-in-law of any Insured Person.

INSURED PERSON means the person(s) named in the policy application or subsequently added and who were approved for coverage by Us until death, lapse of coverage due to non-payment of premiums, cancellation of policy upon the Named Insured's request, or under the Termination of Coverage and Conversion Privileges Provisions.

MAINTENANCE DRUG THERAPY means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of Cancer due to primary treatment. It is meant to decrease the risk of Cancer recurrence rather than the palliative or suppression of Cancer that is still present.

NAMED INSURED means the primary person accepted for coverage by Us, who is described in the application and has completed and signed the application.

PATHOLOGICAL DIAGNOSIS means a Diagnosis of Cancer or Carcinoma in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical Advice or Treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the policy.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this policy is in force.

SKIN CANCER means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, mycosis fungoides or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.

SPOUSE means the person who is lawfully married and named on the application as the Spouse to be insured at the time You first applied for this coverage, or who was added at a later date. There may never be more than one (1) Spouse insured at any given time.

PART 2: ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

AT THE TIME THE POLICY IS ISSUED: Before coverage becomes effective for each Insured Person:
(1) You must apply;
(2) We must approve Your application; and
(3) You must pay the required premium.

Applicants must be acceptable to Us based on Our underwriting rules in effect at the time of application to become an Insured Person. The effective date of insurance for each such person will be the Effective Date shown on the Policy Schedule Page.

PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE: Eligible Dependents not covered under the policy when the policy is issued may be added later. To do so, We must receive:
(1) a new application for each Dependent;
(2) evidence satisfactory to Us that such Dependent is eligible and insurable according to Our underwriting guidelines; and
(3) payment of the additional required premium.

The Effective Date of coverage for the added Insured Person will be the later of the date on which We approve the application or the date upon which We receive any additional required premium.

COVERAGE OF NEWBORN OR ADOPTED CHILD(REN): Any Child born to or adopted by the Named Insured while this policy is in force is automatically covered for the first thirty-one (31) days from:
(1) the moment of birth for a newborn Child; or
(2) the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the Child.

In order to continue coverage for a newborn or adopted Child:
(1) We must receive notice within thirty-one (31) days after the date of the Child's birth (or, in the case of an adopted Child, within thirty-one (31) days after placement for adoption or the date of entry of an order granting the adoptive parent custody). The required notice must include the Child's name, gender and date of birth, date of adoption or placement with You; and
(2) You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notification.

The Effective Date of coverage for the added newborn or adopted Child(ren) will be the date of birth for a newborn Child or the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the Child.

PART 3: BENEFITS PROVIDED BY THIS POLICY

FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician, We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

(1) 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
(2) the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

(1) Diagnosis must be made within the United States; and
(2) the Date of Diagnosis shall occur while the Insured Person is covered by this policy; and
(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the policy. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this policy's Effective Date, coverage for the Insured Person under the this policy will end.

PART 4: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy:

(1) for any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
(2) loss that begins prior to the Effective Date of coverage;
(3) Diagnosis and treatment received outside the United States or its territories; or
(4) any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 5: PREMIUM PAYMENTS AND REINSTATEMENT

INITIAL: This policy is issued based on the application, Our underwriting requirements and payment of the initial premium. The policy begins on the Effective Date shown on the Policy Schedule Page. All periods of insurance will begin and end at 12:01 a.m., at the place where You live.

RENEWAL: All renewal premiums must be paid in consecutive terms. They shall be paid by modes currently offered by Us. Renewal premiums are payable to Us. Premiums must be paid on or before the date due or before the end of the grace period. If this policy should lapse, the payment of a premium will reinstate this policy only as provided in the reinstatement provision in this section.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium, falling due after the first premium. This policy will continue in force during the grace period. If the premium due is not paid during the grace period, the policy will terminate coverage at the end of the period for which premiums were paid.

LAPSE AND REINSTATEMENT: If the renewal premium is not paid within the grace period, this policy will terminate on the first premium due date for which premium was not paid. If the policy terminates, Our acceptance of a premium payment without requiring an application for reinstatement will reinstate this policy. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

If We require an application for reinstatement and issue a conditional receipt, this policy will be reinstated upon Our approval of the reinstatement application. If We do not notify You in writing of Our prior approval or disapproval, this policy will automatically be reinstated on the forty-fifth (45th) day following the date of the conditional receipt.

The reinstated policy shall cover losses resulting from such accidental injury as may be sustained after the date of reinstatement. The reinstated policy shall also cover specified diseases due to a Sickness as may begin more than ten (10) days after the reinstatement date. In all other respects, Your rights and Ours will remain the same, subject to any restrictions attached in connection with the reinstatement.

PART 6: TERMINATION OF COVERAGE PROVISION

TERMINATION OF AN INSURED PERSON'S COVERAGE: Coverage under this Policy will terminate on the earliest of:

(1) the date premiums are not received when due, subject to the Grace Period provision;
(2) the date You specify in Your written request for termination;
(3) the date an Insured Person dies;
(4) the date the reduced Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ is paid during the first thirty (30) days immediately following the Effective of the policy; or
(5) the date 100% of the Recurrence Benefit Amount is paid.

INSURED CHILD TERMINATION OF COVERAGE: An Insured Child shall cease to be covered on the premium due date on or next following the earlier of such Child's:

(1) nineteenth (19th) birthday; or twenty-sixth (26th) birthday if a full-time student; or
(2) date of marriage.

The coverage of an Insured Child will not terminate if the Child is both: (1) incapable of self-sustaining employment because of mental incapacity or physical handicap; and (2) currently dependent upon You for support and maintenance. We must receive proof of incapacity and dependency within thirty-one (31) days of the Child's attainment of the limiting age. Then, coverage will continue for as long as Your insurance stays in force and such Child remains incapacitated. Additional proof may be required from time to time but not more often than once a year, unless such information is requested as a part of Our claim processing.

INSURED SPOUSE TERMINATION OF COVERAGE: Your Spouse's coverage shall cease on the premium due date on or next following Our receipt of written notice of a valid judgment of dissolution of marriage, or legal separation and a copy of that order.

AT TERMINATION OF YOUR COVERAGE: When Your coverage terminates as a result of (1) Your death; (2) Your receipt of payment for the reduced Benefit Amount; or (3) Your receipt of payment for 100% of the Recurrence Benefit Amount the following will apply:

(1) If this is a policy that includes coverage for You and Your Spouse or You, Your Spouse and Child(ren), Your Spouse will become the Named Insured. Your Spouse must notify Us in writing within sixty (60) days after Your death to continue coverage; or
(2) If this is a policy that includes You and Your Child(ren), the coverage ceases for all Insured Persons.

It is Your responsibility to notify Us of any Dependent's loss of eligibility for coverage. Our acceptance of premium for any person for whom coverage has terminated will not extend coverage for such person. We will be responsible for only the refund of any unearned premium.

Termination of coverage because a person ceases to be an Insured Person is without prejudice to any claim originating prior to termination of coverage.

PART 7: CONVERSION PRIVILEGES PROVISION

CONVERSION PRIVILEGES: A policy of First Diagnosis Cancer (hereinafter called a Conversion Policy) may be applied for if coverage under this policy ends as set forth in the Insured Child Termination of Coverage provision or the Insured Spouse Termination of Coverage provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions.

(1) An application for the Conversion Policy and the first premium must be received by Us within thirty-one (31) days after the date on which the Insured Person's coverage under this policy ends.

(2) The premium for the Conversion Policy will be the premium payable on the Effective Date of the Conversion Policy for the form and amount of coverage provided.

(3) The Effective Date of the Conversion Policy will be the date coverage ends for the Insured Person under this policy.

(4) The Conversion Policy will not provide benefits greater than those provided to the Insured Person under this policy. The converted coverage will be as provided on a substantially similar or comparable policy form then being issued by Us.

(5) Any special provisions that apply to an Insured Person under this policy will also apply under the Conversion Policy.

PART 8: HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of a claim must be given to Us within ninety (90) days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us, with information sufficient to identify You, will be notice to Us.

CLAIM FORMS: When We receive notice of claim, if additional information is required, We will send You forms for filing proof of loss. If We fail to provide these forms within fifteen (15) days after receipt of notice of claim, We agree You will have met the requirements for filing proof of loss, within the time allowed.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of loss. Failure to provide written proof will not invalidate nor reduce any claim if it was not reasonably possible to send such proof within the time allowed, provided such proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will any claim be accepted later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon Our receipt of due written Proof of Loss.

PAYMENT OF CLAIMS: Unless otherwise assigned by You, all benefits payable under this policy will be payable to You during Your lifetime and, any accrued benefits unpaid at Your death will paid to the designated Beneficiary, if any, otherwise to Your estate. If benefits are payable to Your estate, We may pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PART 9: GENERAL INFORMATION

The provisions of the policy set out Your rights and obligations as a Named Insured and Our rights and obligations as Your insurance company.

ENTIRE CONTRACT: This policy, including the application, the riders, the endorsements, the amendments and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by an executive officer of the insurance company in writing. Such officer's approval must be endorsed hereon and attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of the two (2) year period.

No claim for loss incurred that starts after twelve (12) months from the Effective Date of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this policy.

CHANGE OF BENEFICIARY: Unless You make an irrevocable designation of Beneficiary, You reserve the right to change a Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be requisite to assignment of this policy, to any change of Beneficiary or Beneficiaries or to any other changes in this policy.

MISSTATEMENT OF AGE: If You or Your Spouse's age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. If according to the correct age, the coverage would not have become effective, Our liability shall be limited to the refund of all premiums paid for the period not covered.

CONFORMITY WITH STATE STATUTES AND/OR INSURANCE REGULATIONS: Any provision of this policy, which, on its Effective Date, is in conflict with the statutes, and/or insurance regulations of the State where You reside is hereby amended to conform to the minimum requirements of such statutes and/or regulations.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought to recover on this policy more than three (3) years after the time written Proof of Loss is required to be furnished.

PHYSICAL EXAMINATION AND AUTOPSY: We, at Our own expense, have the right and opportunity to examine any Insured Person when and as often as We may reasonably require during the pendency of a claim and to require an autopsy in case of death where it is not forbidden by law.

CANCELLATION: You may cancel this policy at any time by notifying Us. Your cancellation will be effective upon receipt of Your notice or on such later date as may be specified in such notice. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

REFUND OF UNEARNED PREMIUM: If an Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

Loyal American
Life Insurance Company®

[P.O. Box 559004, Austin, TX 78755-9004]
Toll Free: [800-633-6752]

FIRST DIAGNOSIS HEART AND STROKE INSURANCE POLICY

Here is Your new First Diagnosis Heart and Stroke Insurance Policy. The language used is easy to understand. Loyal American Life Insurance Company® will be referred to in this policy as "We", "Our", and "Us". "You" or "Your" means the Named Insured.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

RIGHT TO ADJUST FUTURE PREMIUMS. After this policy has been in force for twelve (12) months, We may change the premium rates only if We change them for all policies like Yours in Your state on a premium class basis. A premium class basis is determined by such factors as benefits, age, gender, geographic location, tobacco use and the year the policy is issued. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. If We change the premium rates for all policies of this form issued by Us and in force in Your state, We will inform You in writing at least thirty (30) days before the change occurs at the address shown in Our records.

PRE-EXISTING CONDITION(S). The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s).

IMPORTANT NOTICE! PLEASE READ. Please read the copy of the application attached to this policy. The best time to clear up any questions is now, before a claim arises. Omissions or misstatements in the application could cause an otherwise valid claim to be denied or coverage to be rescinded. Carefully check the application and write to Loyal American Life Insurance Company at [P.O. Box 559004, Austin, Texas 78755-9004] within ten (10) days if any information shown on it is not correct and complete or if any medical history has been left out. The application is a part of this policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

YOU HAVE THE RIGHT TO EXAMINE THIS POLICY FOR THIRTY (30) DAYS. Please read Your policy carefully. If You are not satisfied with Your policy for any reason, You may return the policy to Us. It must be returned within thirty (30) days from receipt of this policy. If returned, the policy will be void from its beginning as though the policy was never issued. Any premium paid on this policy will be refunded.

NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY. THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

[Brenda Hardison]
Secretary

[ ]
President

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PART 1: DEFINITIONS

When We use the following words, this is what We mean:

BENEFICIARY means the person(s) You named in the application, or by later designation, to receive any death benefit or accrued benefits unpaid at Your death.

BENEFIT AMOUNT means the amount We will pay for a covered benefit as shown on the Policy Schedule Page.

CHILD(REN) means Your natural child, stepchild, legally adopted child, a foster child, or court appointed guardianship/order/administrative order for a child including grandchild, who is:
(1) insurable and named on the application;
(2) unmarried;
(3) chiefly dependent on You or Your Spouse for support; and
(4) has not attained the limiting age of nineteen (19) or twenty-six (26) if enrolled as a full-time student in an accredited school or college.

Children may also include a child placed with You for adoption. Such coverage will begin on the date of the filing of a petition for adoption if the coverage is applied for within 60 days after the filing of the petition of adoption. In the case of a newborn, the coverage shall be from the moment of birth if the petition and application for coverage is within 60 days after birth.

Child(ren) also includes dependent child(ren), regardless of age, who:
(1) are mentally or physically handicapped;
(2) became or become handicapped prior to the limiting Age; and
(3) cannot support themselves because of their handicap.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under this policy, through the use of pathological, clinical and/or laboratory findings as supported by the Insured Person's medical records.

DEPENDENTS means Your Spouse and Child(ren) as defined under this section.

DIAGNOSIS and **DIAGNOSED** mean the definitive establishment of a Qualifying Event through the use of pathological, clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under this policy.

FIRST EVER DIAGNOSIS OR PROCEDURE means the Diagnosis or procedure is the first time ever in the Insured Person's lifetime they have undergone that specific covered procedure or been Diagnosed with that specific disease or condition.

IMMEDIATE FAMILY means anyone related to an Insured Person in the following manner: the Spouse, father (including stepfather), mother (including stepmother), sons (including stepsons), daughters (including stepdaughter), brothers or sisters (including stepbrothers or stepsisters), grandchildren, or father-in-law or mother-in-law of any Insured Person.

INSURED PERSON means the person(s) named in the policy application or subsequently added and who were approved for coverage by Us until death, lapse of coverage due to non-payment of premiums, cancellation of policy upon the Named Insured's request, or under the Termination of Coverage and Conversion Privileges Provisions.

NAMED INSURED means the primary person accepted for coverage by Us, who is described in the application and has completed and signed the application.

PHYSICIAN means a practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or injuries. Such person must not be the Named Insured, an Insured Person, an Insured Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

PRE-EXISTING CONDITION means a condition Diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the twelve (12) months prior to the Effective Date of the policy.

QUALIFYING EVENTS means one (1) of the diseases, conditions or procedures listed below for which benefits may be payable.

ANGIOPLASTY means reconstitution or recanalization of a blood vessel. It may involve balloon dilation, mechanical stripping of intima, or forceful injection of fibrinolytics. The procedure must be performed by a Physician who is a board certified cardiologist. Placement of a stent or other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

AORTIC SURGERY means undergoing surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be performed by a Physician who is a board certified cardiologist, cardiovascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

CORONARY ARTERY BYPASS SURGERY means open heart surgery to correct narrowing or blockage of one (1) or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, or other nonsurgical procedures. This surgery requires placement of the patient on a cardiac-pulmonary bypass machine and must be performed by a Physician who is a board certified cardiothoracic surgeon. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

HEART ATTACK means the myocardial infarction, coronary thrombosis or coronary occlusion that is Diagnosed or treated after the policy Effective Date. The following are not considered as a Heart Attack: congestive heart failure, atherosclerotic heart disease, an EKG change consistent with transient ischemic change, angina, chance finding of EKG changes suggestive of a previous Heart Attack, coronary artery disease or any other dysfunction of the cardiovascular system, or death of the heart muscle coincident with death of an Insured Person from other causes. Diagnosis of a Heart Attack must be positively made by a Physician who is board certified and be based on **all** of the following criteria:

(1) associated new EKG changes consistent with injury;
(2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
(3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

HEART TRANSPLANT means a surgery in which an Insured Person receives, from a suitable donor and in accordance with generally accepted medical procedures, as a result of a surgical transplant, a heart, heart-lung or other combination transplant including heart. In order for the transplant to be covered under this policy, the Insured Person must be registered by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). **It does not include transplants involving mechanical or non-human organs.**

HEART VALVE REPLACEMENT/REPAIR SURGERY means undergoing open heart surgery to replace or repair one (1) or more valves. The surgery must be performed by a Physician who is a board certified cardiologist or cardiovascular surgeon.

STENTS means the surgical placement of a stent for the purpose of correcting narrowing or blockage of one (1) or more coronary arteries caused by heart disease.

STROKE means an acute cerebral vascular accident (due to rupture or acute occlusion of a cerebral artery) producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit, positively Diagnosed by a Physician, persisting for at least thirty (30) days. This definition of stroke shall specifically exclude Transient Ischemic Attacks, attacks of Vertebrobasilar Ischemia, head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits. The Diagnosis must be made by a Physician who is a board certified neurologist.

SICKNESS means an illness or disease incurred by an Insured Person which first manifests itself after the Effective Date and while this policy is in force.

SPOUSE means the person who is lawfully married and named on the application as the Spouse to be insured at the time You first applied for this coverage, or who was added at a later date. There may never be more than one (1) Spouse insured at any given time.

PART 2: ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

AT THE TIME THE POLICY IS ISSUED: Before coverage becomes effective for each Insured Person:
(1) You must apply;
(2) We must approve Your application; and
(3) You must pay the required premium.

Applicants must be acceptable to Us based on Our underwriting rules in effect at the time of application to become an Insured Person. The effective date of insurance for each such person will be the Effective Date shown on the Policy Schedule Page.

PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE: Eligible Dependents not covered under the policy when the policy is issued may be added later. To do so, We must receive:
(1) a new application for each Dependent;
(2) evidence satisfactory to Us that such Dependent is eligible and insurable according to Our underwriting guidelines; and
(3) payment of the additional required premium.

The Effective Date of coverage for the added Insured Person will be the later of the date on which We approve the application or the date upon which We receive any additional required premium.

COVERAGE OF NEWBORN OR ADOPTED CHILD(REN): Any Child born to or adopted by the Named Insured while this policy is in force is automatically covered for the first thirty-one (31) days from:
(1) the moment of birth for a newborn Child; or
(2) the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the Child.

In order to continue coverage for a newborn or adopted Child:
(1) We must receive notice within thirty-one (31) days after the date of the Child's birth (or, in the case of an adopted Child, within thirty-one (31) days after placement for adoption or the date of entry of an order granting the adoptive parent custody). The required notice must include the Child's name, gender and date of birth, date of adoption or placement with You; and
(2) You must meet the requirements under PERSONS WHO BECOME ELIGIBLE AFTER THE EFFECTIVE DATE within thirty-one (31) days of the date We received the above notification.

The Effective Date of coverage for the added newborn or adopted Child(ren) will be the date of birth for a newborn Child or the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the Child.

PART 3: BENEFITS PROVIDED BY THIS POLICY

FIRST DIAGNOSIS HEART AND STROKE BENEFIT: We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

(1) The First Ever Diagnosis or Procedure must be made and performed within the United States; and

(2) the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this policy; and

(3) payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this policy. Payment of benefits is subject to all terms and conditions of this policy.

PART 4: EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy for:

(1) any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
(2) intentionally self-inflicted injury or Sickness;
(3) suicide or attempted suicide, while sane or insane;
(4) loss that begins prior to the Effective Date of coverage;
(5) Diagnosis and treatment received outside the United States or its territories;
(6) any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
(7) any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this policy.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

PART 5: PREMIUM PAYMENTS AND REINSTATEMENT

INITIAL: This policy is issued based on the application, Our underwriting requirements and payment of the initial premium. The policy begins on the Effective Date shown on the Policy Schedule Page. All periods of insurance will begin and end at 12:01 a.m., at the place where You live.

RENEWAL: All renewal premiums must be paid in consecutive terms. They shall be paid by modes currently offered by Us. Renewal premiums are payable to Us. Premiums must be paid on or before the date due or before the end of the grace period. If this policy should lapse, the payment of a premium will reinstate this policy only as provided in the reinstatement provision in this section.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium, falling due after the first premium. This policy will continue in force during the grace period. If the premium due is not paid during the grace period, the policy will terminate coverage at the end of the period for which premiums were paid.

LAPSE AND REINSTATEMENT: If the renewal premium is not paid within the grace period, this policy will terminate on the first premium due date for which premium was not paid. If the policy terminates, Our acceptance of a premium payment without requiring an application for reinstatement will reinstate this policy. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

If We require an application for reinstatement and issue a conditional receipt, this policy will be reinstated upon Our approval of the reinstatement application. If We do not notify You in writing of Our prior approval or disapproval, this policy will automatically be reinstated on the forty-fifth (45^{th}) day following the date of the conditional receipt.

The reinstated policy shall cover losses resulting from such accidental injury as may be sustained after the date of reinstatement. The reinstated policy shall also cover specified diseases due to a Sickness as may begin more than ten (10) days after the reinstatement date. In all other respects, Your rights and Ours will remain the same, subject to any restrictions attached in connection with the reinstatement.

PART 6: TERMINATION OF COVERAGE PROVISION

TERMINATION OF AN INSURED PERSON'S COVERAGE: Coverage under this Policy will terminate on the earliest of:

(1) the date premiums are not received when due, subject to the Grace Period provision;
(2) the date You specify in Your written request for termination;
(3) the date an Insured Person dies; or
(4) the date 100% of the First Diagnosis Heart and Stroke Benefit Amount is paid.

INSURED CHILD TERMINATION OF COVERAGE: An Insured Child shall cease to be covered on the premium due date on or next following the earlier of such Child's:

(1) nineteenth (19th) birthday; or twenty-sixth (26th) birthday if a full-time student; or
(2) date of marriage.

The coverage of an Insured Child will not terminate if the Child is both: (1) incapable of self-sustaining employment because of mental incapacity or physical handicap; and (2) currently dependent upon You for support and maintenance. We must receive proof of incapacity and dependency within thirty-one (31) days of the Child's attainment of the limiting age. Then, coverage will continue for as long as Your insurance stays in force and such Child remains incapacitated. Additional proof may be required from time to time but not more often than once a year, unless such information is requested as a part of Our claim processing.

INSURED SPOUSE TERMINATION OF COVERAGE: Your Spouse's coverage shall cease on the premium due date on or next following Our receipt of written notice of a valid judgment of dissolution of marriage, or legal separation and a copy of that order.

AT TERMINATION OF YOUR COVERAGE: When Your coverage terminates as a result of (1) Your death; or (2) Your receipt of payment for 100% of the First Diagnosis Heart and Stroke Benefit Amount the following will apply:

(1) If this is a policy that includes coverage for You and Your Spouse or You, Your Spouse and Child(ren), Your Spouse will become the Named Insured. Your Spouse must notify Us in writing within sixty (60) days after Your death to continue coverage; or
(2) If this is a policy that includes You and Your Child(ren), the coverage ceases for all Insured Persons.

It is Your responsibility to notify Us of any Dependent's loss of eligibility for coverage. Our acceptance of premium for any person for whom coverage has terminated will not extend coverage for such person. We will be responsible for only the refund of any unearned premium.

Termination of coverage because a person ceases to be an Insured Person is without prejudice to any claim originating prior to termination of coverage.

PART 7: CONVERSION PRIVILEGES PROVISION

CONVERSION PRIVILEGES: A policy of First Diagnosis Heart and Stroke (hereinafter called a Conversion Policy) may be applied for if coverage under this policy ends as set forth in the Insured Child Termination of Coverage provision or the Insured Spouse Termination of Coverage provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions:

PART 7: CONVERSION PRIVILEGES PROVISION (Continued)

(1) An application for the Conversion Policy and the first premium must be received by Us within thirty-one (31) days after the date on which the Insured Person's coverage under this policy ends.
(2) The premium for the Conversion Policy will be the premium payable on the Effective Date of the Conversion Policy for the form and amount of coverage provided.
(3) The Effective Date of the Conversion Policy will be the date coverage ends for the Insured Person under this policy.
(4) The Conversion Policy will not provide benefits greater than those provided to the Insured Person under this policy. The converted coverage will be as provided on a substantially similar or comparable policy form then being issued by Us.
(5) Any special provisions that apply to an Insured Person under this policy will also apply under the Conversion Policy.

PART 8: HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of a claim must be given to Us within ninety (90) days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us, with information sufficient to identify You, will be notice to Us.

CLAIM FORMS: When We receive notice of claim, if additional information is required, We will send You forms for filing proof of loss. If We fail to provide these forms within fifteen (15) days after receipt of notice of claim, We agree You will have met the requirements for filing proof of loss, within the time allowed.

PROOF OF LOSS: Written proof of loss must be furnished to Us within ninety (90) days after the date of loss. Failure to provide written proof will not invalidate nor reduce any claim if it was not reasonably possible to send such proof within the time allowed, provided such proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will any claim be accepted later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon Our receipt of due written Proof of Loss.

PAYMENT OF CLAIMS: Unless otherwise assigned by You, all benefits payable under this policy will be payable to You during Your lifetime and, any accrued benefits unpaid at Your death will paid to the designated Beneficiary, if any, otherwise to Your estate. If benefits are payable to Your estate, We may pay benefits up to $1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PART 9: GENERAL INFORMATION

The provisions of the policy set out Your rights and obligations as a Named Insured and Our rights and obligations as Your insurance company.

ENTIRE CONTRACT: This policy, including the application, the riders, the endorsements, the amendments and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by an executive officer of the insurance company in writing. Such officer's approval must be endorsed hereon and attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of the two (2) year period.

No claim for loss incurred that starts after twelve (12) months from the Effective Date of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this policy.

CHANGE OF BENEFICIARY: Unless You make an irrevocable designation of Beneficiary, You reserve the right to change a Beneficiary and the consent of the Beneficiary or Beneficiaries shall not be requisite to assignment of this policy, to any change of Beneficiary or Beneficiaries or to any other changes in this policy.

MISSTATEMENT OF AGE: If You or Your Spouse's age has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. If according to the correct age, the coverage would not have become effective, Our liability shall be limited to the refund of all premiums paid for the period not covered.

CONFORMITY WITH STATE STATUTES AND/OR INSURANCE REGULATIONS: Any provision of this policy, which, on its Effective Date, is in conflict with the statutes, and/or insurance regulations of the State where You reside is hereby amended to conform to the minimum requirements of such statutes and/or regulations.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought to recover on this policy more than three (3) years after the time written Proof of Loss is required to be furnished.

PHYSICAL EXAMINATION AND AUTOPSY: We, at Our own expense, have the right and opportunity to examine any Insured Person when and as often as We may reasonably require during the pendency of a claim and to require an autopsy in case of death where it is not forbidden by law.

CANCELLATION: You may cancel this policy at any time by notifying Us. Your cancellation will be effective upon receipt of Your notice or on such later date as may be specified in such notice. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

REFUND OF UNEARNED PREMIUM: If an Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

Loyal American
Life Insurance Company®

Application for [First Diagnosis Cancer Insurance Policy] [and/or] [First Diagnosis Heart and Stroke Insurance Policy]

[P.O. Box 559015, Austin, TX 78755-9015, 800-633-6752]

Application is for: [☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Requested Effective Date _____ [Existing Policy Number _____] [PV Case #_____]

SECTION A: APPLICANT'S INFORMATION (Please Print)

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ Email _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (If other than Applicant) Payor Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION (Please Print)

SPOUSE TO BE COVERED

First | MI | Last

Date of Birth

Month | Day | Year | Sex | Age | Height (Ft/In) | Weight | Social Security #

Work Phone ( ) _____ Home Phone ( ) _____

Best Time to Call (Provide a 2+ Hour Time Period): From _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

CHILD(REN) TO BE COVERED (Please attach a separate sheet if needed.)

	Name: First, MI, Last	Social Security #	Sex	Age	Date of Birth Month/Day/Year	Full Time Student?
Child # 1						☐ Y ☐ N
Child # 2						☐ Y ☐ N
Child # 3						☐ Y ☐ N
Child # 4						☐ Y ☐ N

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If yes, have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant: _____ Spouse: _____

Applicant Employer/Job: _____ Title/Duties: _____

Spouse Employer/Job: _____ Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) *Complete the Electronic Funds Transfer Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ DIRECT BILL]
[Premium Mode: [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

[☐ LIST BILL]
[Pemium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay] [☐ 52 Pay]]

[Group Name: _____] [Group Number: _____]
[Is this a Section 125? ☐ Yes ☐ No]

[☐ CREDIT CARD *Complete the Credit Card Payment Authorization Form*]
[Premium Mode: [☐ Monthly] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually]]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Cancer (FDC) Policy* Benefit Amount: $ _____ Base Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ First Diagnosis Heart/Stroke (FDH) Policy** Benefit Amount:$ _____ Base Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

*[(*FDC Policy can not be written with FDC Rider; **FDH Policy can not be written with FDH Rider)]*

[Total Base Modal Premium $ _____]

[OPTIONAL RIDERS SELECTION *(for additional premium)*]

[☐ First Diagnosis Cancer (FDC) Rider* Benefit Amount: $ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ First Diagnosis Heart/Stroke (FDH) Rider** Benefit Amount:$ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

*[(*FDC Rider can not be written with FDC Policy; **FDH Rider can not be written with FDH Policy)]*

[☐ Specified Disease Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]
[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider [☐ $25,000] [☐ $50,000] [☐ $75,000] [☐ $100,000]
[(if applying, Child(ren) benefit is $[25,000])] Rider Modal Premium $ _____]

[Total Optional Riders Modal Premium $ _____]

[OPTIONAL RETURN OF PREMIUM RIDER[S] SELECTION *(for additional premium)*]

Select One: [☐ Return of Premium)] [☐ Return of Premium Upon Termination (15 Years)]
[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]

[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

Total Base[/Optional Riders/][Optional ROP Rider] Modal Premium $ _____]

[One Time Enrollment Fee $ _____]

[Total Premium with Application $ _____]

Make checks payable to Loyal American Life Insurance Company

SECTION G: NON-MEDICAL QUESTIONS

	YES	NO
1. Does any applicant currently have any Accident, Cancer or Heart insurance coverage in force? If yes, list the name of Company and Policy Number and Coverage Amount.	☐	☐
2. Is the Insurance applied for here intended to replace any existing or pending Accident, Cancer or Heart insurance? If yes, complete the provided replacement form, and list the name of Company and Policy Number	☐	☐
3. During the past five (5) years, has any applicant had an Accident, Cancer or Heart insurance application postponed, rated up or declined, or had insurance renewal or reinstatement refused?	☐	☐
4. Is any applicant eligible for Medicare?	☐	☐
5. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)?	☐	☐

SECTION H: TOBACCO USE

	Applicant	Spouse
Have you used tobacco within the last five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION I: MEDICAL QUESTIONS

(If the answer to any question in this section is YES the applicant is not eligible for coverage.)

ALL POLICIES AND RIDERS (*Please Answer Questions #1 - #2*)

	YES	NO
1. Have you or any applicant ever been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS),AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV) Infection?	☐	☐
2. Within the past five (5) years, have you or any applicant received, been advised to receive, or sought any medical advice, examination, or treatment for drug or alcohol abuse, addiction, or dependency?	☐	☐

FIRST DIAGNOSIS CANCER POLICY/RIDER *(Please Answer Questions #3 - #5)*

	YES	NO
3. Have you or any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
4. Have you or any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
5. Have you or any applicant ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

FIRST DIAGNOSIS HEART/STROKE POLICY/RIDER [AND SPECIFIED DISEASE RIDER]
(Please Answer Questions #6 - #7)

	YES	NO
6. Have you or any applicant ever:		
a. Been diagnosed with or received medical advice or treatment for Heart Attack, Angina, Arrhythmia, Congenital Heart Defect,Cardiomyopathy, Congestive Heart Failure, Coronary Artery Disease (CAD), Carotid Artery Disease,Peripheral Vascular Disease, Cardiac or Vascular Angioplasty, Stroke, Transient Ischemic Attack (TIA), Pulmonary Hypertension, Blood Clots, or Disease or Disorder of the Heart or Circulatory System not listed?	☐	☐
b. Had or been advised to have any form of Heart or Heart Valve Surgery, Coronary Artery Surgery, Bypass Surgery, Endarterectomy, Arteriogram, Cardiac or Vascular Angioplasty, Stent Placement, or Implantation of Cardiac Pacemaker or Defibrillator?	☐	☐
c. Been diagnosed with or received medical advice or treatment for Insulin Dependent Diabetes (excluding Gestational Diabetes), Diabetes with Neuropathy or Retinopathy or Connective Tissue Disorders such as Cystic Fibrosis?	☐	☐
d. Been prescribed three (3) or more medications to be taken concurrently for High Blood Pressure?	☐	☐

FIRST DIAGNOSIS HEART/STROKE POLICY/RIDER [AND SPECIFIED DISEASE RIDER] *(Continued)*

	YES	NO
7. Within the last six (6) months have you or any applicant:		
a. Been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	☐	☐
b. Had three (3) or more blood pressure readings over 140/90?	☐	☐
c. Been advised that your blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure?	☐	☐

[SPECIFIED DISEASE RIDER *(Please Answer Questions #8 - #9)*

	YES	NO
8. Have you or any applicant ever been diagnosed with or received medical advice or treatment for any of the following conditions?		
a. Kidney Disease requiring dialysis, Renal Insufficiency, Renal Failure, or Polycystic Kidney Disease?	☐	☐
b. Liver Disease including Cirrhosis or Hepatitis (other than A)?	☐	☐
c. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Obstructive Lung Disease (COLD) excluding Asthma, Pulmonary Fibrosis or any Lung or Respiratory Disorder requiring the use of oxygen?	☐	☐
d. Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), or Paralysis?	☐	☐
9. Have you or any applicant ever had an Organ transplant, bone marrow transplant or been advised of a need for a transplant?	☐	☐

[ACCIDENTAL DEATH AND DISMEMBERMENT RIDER *(Please Answer Questions #[10] & #[11])*

	YES	NO
10. Has any applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last five (5) years?	☐	☐
11. Has any applicant participated in or intend to participate in, and/or is currently participating in piloting, parachuting, sky diving, hang-gliding, motor racing, sporting activity(ies) for wage, compensation or profit, or any other hazardous activity(ies)	☐	☐

SECTION J: MEDICATION(S) *(REQUIRED FOR ALL POLICIES AND RIDERS)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Dates Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); (3) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (4) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.
THIS POLICY PROVIDES LIMITED BENEFITS, REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I or any applicant now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ **Date:** _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the applicant. The applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant 's Statements and Agreements

Was the application completed by you in the applicant's physical presence?..... ☐ Yes ☐ No

Was the application completed by you over the phone?..... ☐ Yes ☐ No

I further certify that on _____ I delivered the documents to the applicant ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax
(Date) (check all that apply, must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage

Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage

Loyal American
Life Insurance Company®
[PO Box 559015 | Austin, TX 78755-9015 | 800-633-6752]

Application for First Diagnosis Cancer Insurance Policy

Application is for:

[☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Best Time to Call: from _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Requested Effective Date: _____ [Existing Policy Number _____] [PV Case # _____]

SECTION A: APPLICANT'S INFORMATION *(Please Print)*

First	MI	Last

Social Security Number	Sex	Date of Birth Month	Day	Year	Age	Height (feet-inches)	Weight (lbs.)

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ E-mail Address _____

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (if other than Applicant) Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION

	Print Name (First, MI, Last)	Social Security#	Date of Birth Mo	Day	Yr	Age	Sex	Height Ft	In	Weight Lbs
Spouse										
Child 1	*Please list youngest child first*							F/TStudent? ☐ Y ☐ N		
Child 2								F/TStudent? ☐ Y ☐ N		
Child 3								F/TStudent? ☐ Y ☐ N		
Child 4								F/TStudent? ☐ Y ☐ N		
Child 5								F/TStudent? ☐ Y ☐ N		
Child 7								F/TStudent? ☐ Y ☐ N		
Child 7								F/TStudent? ☐ Y ☐ N		

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If "Yes", have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant _____ Spouse _____

Applicant Employer/Job: _____ Spouse Employer/Job: _____

Applicant Title/Duties: _____ Spouse Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) - *Complete the Electronic Funds Transfer Authorization Form]*

[☐ CREDIT CARD - *Complete the Credit Card Payment Authorization Form*]

[☐ DIRECT BILL]

[☐ LIST BILL]

[Group Name: _____] [Group Number: _____]

[Is this a Section 125? ☐ Yes ☐ No]

Mode:

[☐ Monthly *(not available with Direct Bill)*] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay *(List Bill only)*] [☐ 52 Pay *(List Bill only)*]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Cancer Policy Benefit Amount: $ _____ Total Base Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[OPTIONAL RIDERS SELECTION (for additional premium)]

[☐ First Diagnosis Heart/Stroke Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Specified Disease Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000]

[(if applying, Child(ren) benefit amount is $[25,000])] Rider Modal Premium $ _____]

Total Optional Riders Modal Premium $ _____]

[OPTIONAL RETURN OF PREMIUM RIDER SELECTION (for additional premium)]

Select One: [☐ Return of Premium] [☐ Return of Premium Upon Termination (15 Years)]

[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]

[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

[Total Base [Optional Riders][/Optional ROP Rider] Modal Premium $ _____]

[One-time Enrollment Fee $ _____]

Total Premium with Application $ _____

Make checks payable to *Loyal American Life Insurance Company*

SECTION G: NON-MEDICAL QUESTIONS

YES NO

1. Does any applicant currently have any health insurance (excluding accident only) in force or pending? ☐ ☐
   If yes, list the name of company, type of policy, policy number, and coverage amount.

2. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance? ☐ ☐
   If yes, complete the provided replacement form, and list the name of company and policy number.

3. Is any applicant eligible for Medicare? ☐ ☐

[4. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)?] ☐ ☐

[SECTION H: TOBACCO USE

Have you used tobacco within the last five (5) years? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

[SECTION I: MEDICAL QUESTIONS - PART 1]

[(If any Applicant answers "Yes" to questions [1] through [11] in this section, he or she is not eligible for coverage. Do not submit this Application.]

FIRST DIAGNOSIS CANCER POLICY *(Please Answer Questions #1 - #5)*

YES NO

1. Has any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, or Malignant Tumors? ☐ ☐
2. Has any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal? ☐ ☐
3. Within the last 5 years, has any applicant had elevated PSA levels greater than 6.0 or had Cervical Dysplasia diagnosed at CIN level III or has any applicant been diagnosed with Carcinoma In Situ? ☐ ☐

YES NO

4. Has any applicant been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection? ☐ ☐
5. Within the past 5 years, has any applicant had, been diagnosed with, treated for or taken medication for drug alcohol or chemical dependency or abuse including alcoholism or illegal drug use or been charged with driving under the influence (DUI) or drugs or alcohol? ☐ ☐

[FIRST DIAGNOSIS HEART/STROKE RIDER] [AND] [SPECIFIED DISEASE RIDER] *(Please Answer Questions #6 - #9)*

YES NO

6. Within the last 5 years, has any applicant had, been diagnosed with, treated for, or taken medication for any of the following:
   a) Disease or Disorder of the Heart including the Heart Valves, Circulatory System (other than high blood pressure), Stroke, TIA, Aneurysm, Blood Clot, or Pulmonary Hypertension?..... ☐ ☐
   b) Insulin Dependent Diabetes (excluding Gestational Diabetes)? ☐ ☐
7. Has any applicant ever had, been diagnosed with, treated for or taken medication for Connective Tissue Disorder? ☐ ☐
8. Within the last 6 months, has any applicant:
   a) Had or been advised to have diagnostic tests performed to evaluate symptoms of chest pains, shortness of breath, blackouts, fainting, or dizziness? ☐ ☐
   b) Had three (3) or more blood pressure readings over 140/90 by a licensed medical professional? ☐ ☐
   c) Been advised that their blood pressure is uncontrolled and/ or advised to take blood pressure medication due to uncontrolled blood pressure? ☐ ☐

YES NO

9. Within the last 5 years, has any applicant been prescribed 3 or more medications (not including a potassium suplement) to be taken concurrently to control high blood pressure? ☐ ☐

[SPECIFIED DISEASE RIDER] *(Please Answer Questions #9- #11)*

YES NO

9. Has any applicant ever had, been diagnosed with, treated for or taken medication for Chronic Kidney Disease or any kidney disease requiring dialysis or Liver Disease including Cirrhosis or Hepatitis (other than A)? ☐ ☐
10. With the last 5 years, has any applicant had, been diagnosed with, treated for, or taken medication for Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Pulmonary Fibrosis, Tuberculosis, Paralysis or other Disorders of the Nervous System including Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS)?..... ☐ ☐

YES NO

11. Has any applicant ever had an organ transplant, bone marrow transplant, or been advised to need a transplant?Has any applicant ever had an organ transplant, bone marrow transplant, or been advised to need a transplant? ☐ ☐

SECTION J: MEDICATION(S) *(Required for all Policies and Riders)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Date(s) Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (3) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.

THIS POLICY PROVIDES LIMITED BENEFITS; REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I or any applicant now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ Date: _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the Applicant. The Applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

Was the application completed by you in the Applicant's physical presence? ☐ Yes ☐ No

Was the application completed by you over the phone? ☐ Yes ☐ No

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant's Statements and Agreements.

I further certify that on _____ (Date), I delivered the documents to the Applicant: ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax (check all that apply; must select at least one)

Printed Name of [1st] Agent	Signature of [1st] Agent	Writing Number	Percentage
[Printed Name of [2nd] Agent	Signature of [2nd] Agent	Writing Number	Percentage]

Loyal American
Life Insurance Company®
[PO Box 559015 | Austin, TX 78755-9015 | 800-633-6752]

Application for First Diagnosis Heart and Stroke Insurance Policy

Application is for:

[☐ New Business] [☐ Reinstatement] [☐ Benefit Change] [☐ Add Dependent] [☐ Conversion]

Best Time to Call: from _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

Requested Effective Date: _____ [Existing Policy Number _____] [PV Case # _____]

SECTION A: APPLICANT'S INFORMATION *(Please Print)*

First	MI	Last

Social Security Number	Sex	Date of Birth Month	Day	Year	Age	Height (feet-inches)	Weight (lbs.)

Mailing Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ E-mail Address _____

Beneficiary (Full Name) _____ Relationship _____

☐ Payor (if other than Applicant) Name _____ Relationship _____

Payor Mailing Address _____ City _____ State _____ Zip _____

SECTION B: DEPENDENT INFORMATION

	Print Name (First, MI, Last)	Social Security#	Date of Birth Mo	Day	Yr	Age	Sex	Height Ft	In	Weight Lbs
Spouse										
Child 1	*Please list youngest child first*							F/TStudent? ☐ Y ☐ N		
Child 2								F/TStudent? ☐ Y ☐ N		
Child 3								F/TStudent? ☐ Y ☐ N		
Child 4								F/TStudent? ☐ Y ☐ N		
Child 5								F/TStudent? ☐ Y ☐ N		
Child 7								F/TStudent? ☐ Y ☐ N		
Child 7								F/TStudent? ☐ Y ☐ N		

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If "Yes", have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain: Applicant _____ Spouse _____

Applicant Employer/Job: _____ Spouse Employer/Job: _____

Applicant Title/Duties: _____ Spouse Title/Duties: _____

SECTION D: PREMIUM PAYMENT METHOD *(Select one of the following)*

[☐ ELECTRONIC FUNDS TRANSFER (Bank Draft) - *Complete the Electronic Funds Transfer Authorization Form]*

[☐ CREDIT CARD - *Complete the Credit Card Payment Authorization Form*]

[☐ DIRECT BILL]

[☐ LIST BILL]

[Group Name: _____] [Group Number: _____]

[Is this a Section 125? ☐ Yes ☐ No]

Mode:

[☐ Monthly *(not available with Direct Bill)*] [☐ Quarterly] [☐ Semi-Annually] [☐ Annually] [☐ 26 Pay *(List Bill only)*] [☐ 52 Pay *(List Bill only)*]

SECTION E: BENEFIT SELECTION

BASE COVERAGE SELECTION

[☐ First Diagnosis Heart/Stroke Policy Benefit Amount: $ _____ Total Base Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[OPTIONAL RIDERS SELECTION (for additional premium)]

[☐ First Diagnosis Cancer Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Specified Disease Rider Benefit Amount: $ _____ Rider Modal Premium $ _____]

[(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)]

[☐ Accidental Death and Dismemberment Rider ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000]

[(if applying, Child(ren) benefit amount is $[25,000])] Rider Modal Premium $ _____]

Total Optional Riders Modal Premium $ _____]

[OPTIONAL RETURN OF PREMIUM RIDER SELECTION (for additional premium)]

Select One: [☐ Return of Premium] [☐ Return of Premium Upon Termination (15 Years)]

[☐ Return of Premium (86)] [☐ Return of Premium Upon Termination (20 Years)]

[Return of Premium Rider Modal Premium $ _____]

SECTION F: TOTAL MODAL PREMIUM

[Total Base [Optional Riders][/Optional ROP Rider] Modal Premium $ _____]

[One-time Enrollment Fee $ _____]

Total Premium with Application $ _____

Make checks payable to *Loyal American Life Insurance Company*

SECTION G: NON-MEDICAL QUESTIONS

	YES	NO
1. Does any applicant currently have any other health insurance (excluding accident only) in force?	☐	☐
f yes, list the name of company, type of policy, policy number and coverage amount.		
2. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance? If yes, complete the provided replacement form, and list the name of company and policy number.	☐	☐
3. Is any applicant eligible for Medicare?	☐	☐
[4. Is any applicant currently covered by any Title XIX program (Medicaid or any similar name)?	☐	☐]

[SECTION H: TOBACCO USE

Have you used tobacco within the last five (5) years? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

[SECTION I: MEDICAL QUESTIONS - PART 1]

[(If any Applicant answers "Yes" to questions [1] through [11] in this section, he or she is not eligible for coverage. Do not submit this Application.]

FIRST DIAGNOSIS HEART/STROKE POLICY *(Please Answer Questions #1 - #6)*

	YES	NO
1. Within the last 5 years, has any applicant had, been diagnosed with, treated for, or taken medication for any of the following:		
a) Disease or Disorder of the Heart including the Heart Valves, Circulatory System (other than high blood pressure), Stroke, TIA, Aneurysm, Blood Clot, or Pulmonary Hypertension?.....	☐	☐
b) Insulin Dependent Diabetes (excluding Gestational Diabetes)?	☐	☐
2. Has any applicant ever had, been diagnosed with, treated for or taken medication for Connective Tissue Disorder?	☐	☐
3. Within the last 6 months, has any applicant:		
a) Had or been advised to have diagnostic tests performed to evaluate symptoms of chest pains, shortness of breath, blackouts, fainting, or dizziness?	☐	☐
b) Had three (3) or more blood pressure readings over 140/90 by a licensed medical professional?	☐	☐
c) Been advised that their blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure?	☐	☐
4. Within the last 5 years, has any applicant been prescribed 3 or more medications (not including a potassium suplement) to be taken concurrently to control high blood pressure?	☐	☐
5. Has any applicant been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐	☐
6. Within the past 5 years, has any applicant had, been diagnosed with, treated for, or taken medication for drug, alcohol or chemical dependency or abuse including alcoholism or illegal drug use or been charged with driving under the influence (DUI) of drugs or alcohol?	☐	☐

[FIRST DIAGNOSIS CANCER RIDER] [AND] [SPECIFIED DISEASE RIDER] *(Please Answer Questions #6 - #8)*

	YES	NO
6. Has any applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, or Malignant Tumors?	☐	☐
7. Has any applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
8. Within the last 5 years, has any applicant had elevated PSA levels greater than 6.0 or had Cervical Dysplasia diagnosed at CIN level III or has any applicant been diagnosed with Carcinoma In Situ?	☐	☐

[SPECIFIED DISEASE RIDER] *(Please Answer Questions #9- #11)*

	YES	NO
9. Has any applicant ever had, been diagnosed with, treated for or taken medication for Chronic Kidney Disease or any kidney disease requiring dialysis or Liver Disease including Cirrhosis or Hepatitis (other than A)?	☐	☐
10. With the last 5 years, has any applicant had, been diagnosed with, treated for, or taken medication for Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Pulmonary Fibrosis, Tuberculosis, Paralysis or other Disorders of the Nervous System including Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS)?.....	☐	☐
11. Has any applicant ever had an organ transplant, bone marrow transplant, or been advised to need a transplant?Has any applicant ever had an organ transplant, bone marrow transplant, or been advised to need a transplant?	☐	☐

SECTION J: MEDICATION(S) *(Required for all Policies and Riders)*

Please list any prescription medications that you or any applicant have taken within the past two (2) years.

Applicant Name	Medication	Date(s) Taken	Condition Taken For

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (3) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable and if eligible for Medicare the required Guide to Health Insurance for People with Medicare.

THIS POLICY PROVIDES LIMITED BENEFITS; REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for any loss caused by a pre-existing condition which I or any applicant now have, or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): _____ Date: _____

SECTION L: AFFIDAVIT FOR AGENT'S USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the Applicant. The Applicant has read or had read to him or her the completed application.

I also certify that this application ☐ does ☐ does not replace or change any existing coverage.

Was the application completed by you in the Applicant's physical presence? ☐ Yes ☐ No

Was the application completed by you over the phone? ☐ Yes ☐ No

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant's Statements and Agreements.

I further certify that on _____ (Date), I delivered the documents to the Applicant: ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax (check all that apply; must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage
[Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage]

Loyal American Life Insurance Company®

PV Case # _____

Cancer Insurance Addition

(Not valid for tobacco users or if you are applying for a Medicare Supplement policy during an open enrollment period or on a Guaranteed Issue basis.)

[P.O. Box 559015, Austin, TX 78755-9015]

Upon issue of your Medicare Supplement policy, you may qualify for a [$5,000] First Diagnosis Cancer Insurance Policy if you can answer "No" to three additional questions. You may add this important coverage by simply completing and returning this form to the company with your Medicare Supplement application.

HEALTH QUESTIONS *(If the answer to any question in this section is YES, the applicant is not eligible for coverage.)*

		Yes	No
1.	Have you ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
2.	Have you ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
3.	Have you ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

Monthly bank draft rates for [$5,000] of supplemental First Diagnosis Cancer protection:

Issue Ages	Female Rates	Male Rates
[65-69]	[$11.60]	[$16.19]
[70-74]	[$13.52]	[$19.81]
[75-80]	[$14.75]	[$21.72]

The billing frequency for your First Diagnosis Cancer Policy will match your Medicare Supplement Policy. The above rates shown are monthly bank draft rates. Consult our rate chart for other billing frequencies.

Med Supp billing frequency: ☐Monthly ☐Quarterly ☐Semi-Annual ☐Annual

First Diagnosis Cancer Policy Modal Premium $_____

Is the Insurance applied for here intended to replace any existing or pending Cancer insurance? ☐Yes ☐No

If yes, list the Company and Policy Number _____ and complete the applicable replacement form.

I acknowledge and agree that Loyal's issuance of this cancer insurance policy is reliant upon the information contained above and in the application I completed for my Loyal American Medicare Supplement policy which shall become a part of the cancer insurance policy I am purchasing, and any misstatement of material facts contained in either application may result in the rescission of this cancer insurance policy. I understand and agree that (1) there will be no coverage until my application is approved by the Company; (2) the initial premium has been paid; (3) this form and Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance, if applicable, are received at the Home Office; and (4) the policy has been issued by the Company. I understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); and (3) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable the required Guide to Health Insurance for People with Medicare. THIS POLICY IS A FIRST DIAGNOSIS CANCER ONLY POLICY. I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I now have, or have had in the past twelve (12) months.

By signing below, I hereby request that Loyal issue a First Diagnosis Cancer Insurance Policy form number series LY-FDC-BA. I understand my bank account will be drafted for the additional premium and my effective date will be the same as my Medicare Supplement policy.

Applicant's Printed Name	Signature Of Applicant	Date
Agent's Printed Name	Signature Of Agent	Writing Number